The Correctional Service of Canada 1996-1997 Retrospective Report on Inmate Suicides

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Prisoner Suicide: A Review of the Literature

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EXECUTIVE SUMMARY

The following is the Correctional Service of Canada's (CSC) fifth retrospective report on inmate suicides. It presents an overview of all self-inflicted deaths in federal custody for the 1996-97 fiscal year and discusses trends since 1991-92. Three objectives are identified in this report: 1) to provide a description of the scope and nature of the problem, 2) to heighten awareness and learn from experience, and 3) to increase organizational knowledge of inmate suicide.

In addition to profiling each case, this report highlights a number of recommendations made by the various Boards of Investigation. It also includes a recent review of the literature on inmate suicide by Natalie H. Polvi, institutional psychologist at the Regional Psychiatric Centre in Saskatoon (Annex B).

There were 11 inmate suicides recorded in 1996-97. One of these deaths has not been confirmed as a suicide and may have been the result of an autoerotic asphyxiation. As such, the incidence rate of 7.1 deaths per 10 000 offenders is the lowest since CSC first began publishing retrospective reports and hopefully reflects an emerging trend. CSC's ongoing efforts to improve policies and procedures, ensure adequate training for staff, and learn from previous experience may have contributed, at least in part, to this year's lower rate.

All inmates who committed suicide this fiscal year were male between the ages of 20 and 43 and, as seen in previous years, the majority were found in the Québec Region. In one of the incidents, the Board of Investigation could not determine if the death was intentional or the result of an autoerotic asphyxiation.

Inmates who commit suicide in federal penitentiary often share many of the characteristics of offenders who do not. In other words, they tend to be single, male Caucasians housed in medium security institutions. However, a notable feature of those who committed suicide this fiscal year was the violent nature of their offenses. Many of the crimes committed by these individuals received considerable media attention. Five of the eleven inmates had a history of violent sexual offending and five offenders from this sample were serving either a life or indeterminate sentence. One inmate had received a Dangerous Offender designation while another was being processed as such.

The Investigation reports from these incidents typically commended staff for efficient and effective action after discovering a victim. Recommendations included both primary prevention strategies (which focus on the prison environment) and secondary prevention strategies (which focus on the high-risk individual). Some Boards of Investigation have noted a need to adhere more fully to CD 257 (Critical Incident Stress Management). Other issues raised were inadequate communication between staff, unsafe physical environments, and defective equipment. The report concludes with three recommendations for CSC to consider and provides an outline of the organization's response to previous recommendations (Annex A).

FOREWORD

The Correctional Service of Canada (CSC) is responsible for both the custody and care of federal offenders. This duality of purpose is reflected in the organization's mission statement:

> *"The Correctional Service of Canada, as part of the criminal justice system and respecting the rule of law, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure, and humane control".*

CSC's success in providing safe, secure and humane control can be measured in part by the number of violent incidents in its institutions such as suicides, assaults, and murders. Inmate suicide is an important event to monitor because its occurrence devastates family and friends, traumatizes staff, and can generate public concern. The incidence of inmate suicide also serves as a good indicator of the offender population's state of mental health.

CSC conducts internal investigations into every self-inflicted death in custody. The process is essentially inquisitorial in nature. It aims not to apportion blame but to identify all the facts surrounding the inmate's death and examine whether policies and procedures were respected. These investigations result in a final report and the collection of these reports form the basis of a yearly retrospective study.

Robert Watkins conducted the first retrospective study in 1992 whereby a total of 17 suicides were examined. Since then, Jane Laishes from CSC's Health Services Branch has authored every retrospective report. Her three publications considered a total of 66 cases and as can be seen in Table 1, data for the 1992-93 fiscal year was included in the 1994 report.

Table 1. Previous CSC retrospective suicide reports.

Report	Year	Author
Retrospective Study of Inmate Suicides in the Correctional Service of Canada	1992	Robert Watkins
Retrospective Study of Inmate Suicides in the Correctional Service of Canada (April 1992 - March 1994)	1994	Jane Laishes
1994-1995 Retrospective Study of Inmate Suicides in the Correctional Service of Canada	1995	Jane Laishes
Retrospective Study of Inmate Suicides in the Correctional Service of Canada (April 1, 1992 to March 31, 1996)	1996	Jane Laishes

The readership for CSC's Suicide Report is broad and varied. It includes front-line staff, administrators, policy makers, researchers, health service staff, mental health practitioners, external agencies, and the public at large. While many of these groups work toward the same goals (e.g. suicide prevention), each has a different role to play in meeting them. It follows that these various stakeholders will have different needs from this type of report. The author recognizes this challenge and will attempt to align information with as many specific requirements as possible.

The Retrospective Report on Inmate Suicides does not communicate information in an overly specialized or technical way. It is purely descriptive in nature and is not presented as a scholarly publication. With this in mind, the reader should not overgeneralize the findings presented here. Despite its higher rate in inmate populations, suicide is still a rare event. Inferences made about this extremely small sample will be necessarily speculative (e.g. motives, trends, group differences).

Fortunately, previous authors of this report (Watkins & Laishes) have accumulated and organized a great deal of information on offenders who have committed suicide in the federal system. Because the precision of measurement increases with the size of the population being studied, we will soon be able to expose our data to appropriate experimental designs and statistical tests. A separate prospective sample will also be included in future reports. Finally, information on the frequency and nature of parasuicide will be collected and eventually form the basis of a separate report. In the interim, the author will attempt to frame the case studies of this report with the most recent literature on inmate suicide.

The objectives for the 1996-1997 report are as follows:

1) To provide a description of the scope and nature of the situation.

Quantifying the incidence of suicide and some of its demographic characteristics is the first step in planning effective strategies. Therefore, the report will present suicide data for the 1996-1997 fiscal year and profile overall trends since 1991-1992.

Unfortunately, many of the efforts made by CSC staff go unnoticed and unmeasured. While we can easily quantify how many offenders take their lives in any given year, it is far more difficult to describe how many lives may have been saved or improved because of appropriate counselling, programming, or other interventions.

2) To increase awareness and learn from experience.

There is general agreement that inmates are prone to self-injurious behaviour and represent a high-risk group for committing suicide. Suicide is still the leading cause of death in jails within Canada, the United States, Australia, and the United Kingdom (Hayes, 1992). Results from CSC's National Inmate Survey indicate that approximately one-fifth of the inmate population "had thought of taking their own life in the past week". Therefore, this report will serve to remind CSC of the inmate population's vulnerability and help the organization maintain a necessary level of vigilance.

This report also highlights recommendations made by various Boards of Investigation. By identifying shortcomings and sharing best practices, CSC can improve its policies and procedures relating to inmate suicide and hopefully reduce its incidence.

3) To increase our knowledge of suicide.

Correctional experts are of the opinion that a knowledgeable prison staff is critical to suicide prevention (Hayes, 1992). Indeed, certain signs and symptoms have been shown to predict suicidal behaviour. Helping staff develop a basic understanding of these cues will be a primary objective in this report.

The Correctional Service of Canada is fortunate to have a number of mental health professionals with clinical expertise and research interests in the area of inmate suicide. We have therefore invited the field to share their knowledge on this issue. Included in this year's report is a recent review of the literature by Natalie H. Polvi from the Regional Psychiatric Centre in Saskatoon (Appendix A).

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INTRODUCTION

Definitions

For the purposes of this report, the words *suicide* and *suicidal* will refer to self-inflicted behaviour that is intended to bring about one's own death in the shortest term. *Suicidal ideation* will refer to cognitions that can vary from fleeting thoughts that life is not worth living, through very concrete, well-thought-out plans for killing oneself, to an intense delusional preoccupation with self-destruction (Diekstra & Gulbinat, 1993).

The term *parasuicide* covers behaviours that can vary from what are sometimes called suicidal gestures and manipulative attempts, to serious but unsuccessful attempts to kill oneself. It refers to any deliberate act with non-fatal outcome that attempts to cause or actually causes self-harm or without intervention from others would have done so. Habitual self-mutilation is not implied under the term parasuicide (Diekstra & Gulbinat, 1993).

Profile of the inmate population

The Correctional Service of Canada operates 49 penitentiaries (42 for male offenders and 7 for female offenders), 69 parole offices, 17 district offices, and 15 community correctional centres. As well, CSC has access to 168 Community Residential Centres operated by community-based non-profit organizations. At the time of this writing, there were approximately 14 000 offenders in federal custody and another 7 000 offenders on some form of conditional release. Table 2 presents a regional distribution of incarcerated offenders by gender (as of September 1997). It should be noted however that while the actual number of offenders is approximately 14 000, the turnover rate (i.e. the total number of offenders entering federal penitentiary in the fiscal year) was closer to 18 000.

Table 2. Number of incarcerated offenders by region and gender.

	Atlantic	Québec	Ontario	Prairies	Pacific	Total
Male	1 302	3 618	3 428	3 223	1 847	13 418
Female	33	65	104	85	37	324
Total	1 335	3 683	3 532	3 308	1 884	13 742

Incidence of suicide in CSC Federal penitentiaries

A total of 93 inmates committed suicide from the beginning of the 1991-1992 fiscal year to the end of the 1996-1997 fiscal year. As can be seen in Figure 1, there were 11 suicides in 1996-97, one of which may have been the result of an autoerotic asphyxiation. This represents an incidence rate of 7.1 deaths per 10 000 offenders.

While the recent decline in the number of suicides is encouraging, it is still the number one cause of death among federal offenders. As can be seen in Figure 2, inmates are more likely to kill themselves in prison than they are to be murdered by another inmate.

Figure 1. Number of inmate suicides from 1991-92 to 1996-97.

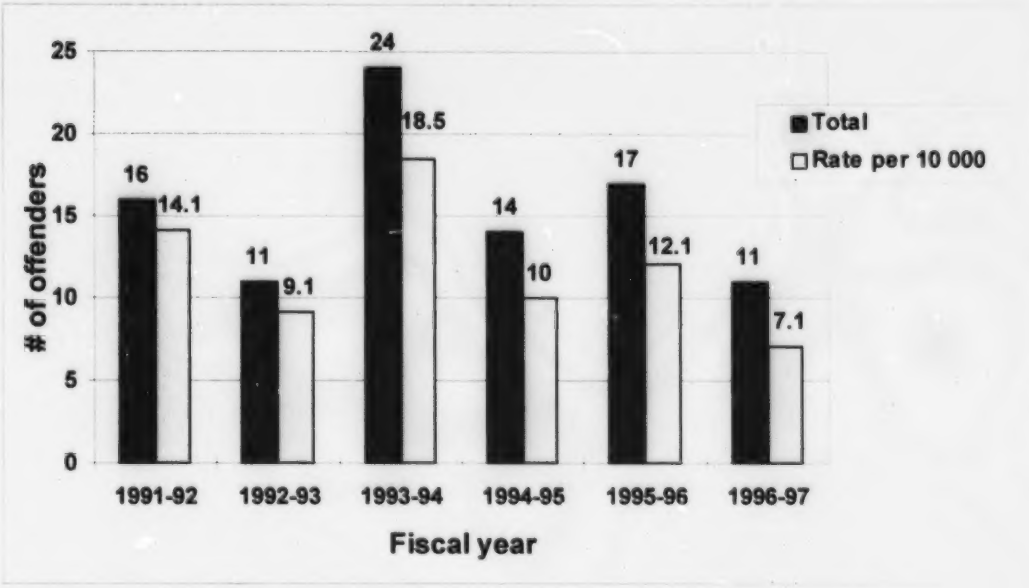
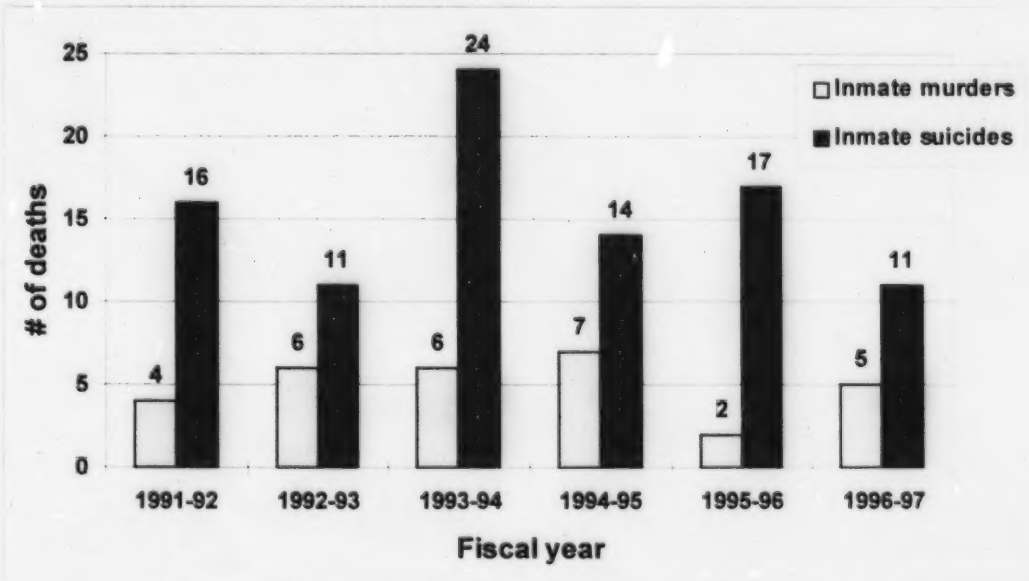


Figure 2. Inmate murder vs. inmate suicide from 1991-92 to 1996-97.



Demographic information

Gender

Suicide in federal custody is almost exclusively a male phenomenon. There have been 92 male suicides and only 1 female suicide since the first publication of this report. This is perhaps not surprising given women's significant under-representation in the correctional system. In fact, its rarer occurrence in Canadian penitentiaries reflects a pattern seen in the general population of Canadians where males commit suicide at a rate 4 times greater than females (Health Canada, 1994). While the absolute numbers discussed here can be misleading, it is practically impossible to present meaningful incidence rates in our extremely small female population (low base rates). However, Liebling (1994) has found that the suicide rate for women imprisoned in England is actually as high as the rate for men. Moreover, there is research indicating that women in custody are more likely to engage in self-destructive behaviours like slashing and head banging (Ramsay, 1987). As such, women should not be considered a low risk group for suicide.

Region

A direct comparison of suicide rates between regions with base populations that differ greatly in size can also be misleading. However, a number of Canadian epidemiological studies have shown higher suicide rates in Québec and Alberta and lower rates in Ontario and Newfoundland (Health Canada, 1994). In the offender population, we see that over the last six years there were almost as many suicides in the Québec region alone than in every other region combined (Table 3). In contrast, suicide in the Pacific region has been an extremely rare event.

Table 3. Number of suicides per region from 1991-92 to 1996-97.

	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	Total
Atlantic	2	0	2	1	1	1	7
Québec	6	9	11	6	8	5	45
Ontario	5	1	5	4	4	4	23
Prairies	2	1	5	3	3	0	14
Pacific	1	0	1	0	1	1	4
Total	16	11	24	14	17	11	93

Table 4 presents other demographic information on inmates who committed suicide over the last five years. To a very large extent, the inmates profiled below resemble inmates in the general population of federal offenders. In other words they were mostly Caucasian, under the age of 39, and serving sentences of 2 to 5 years. In addition,

federal offenders were likely to be single and housed in medium security facilities. On the other hand, there appears to be an overrepresentation of maximum security inmates, single inmates, and inmates serving Life or Indeterminate sentences amongst those who committed suicide. Ongoing research may help us determine if these differences are statistically significant.

Table 4. Demographic information on inmates who committed suicide from 1991-92 to 1996-97 (N=93) compared with the total inmate population.

	91-92	92-93	93-94	94-95	95-96	96-97	Total and *(%)* of Suicide victims	% of all inmates[1]
Age								
20-29 years	8	4	10	4	2	6	34 *(37)*	*32*
30-39 years	4	4	10	4	12	4	38 *(41)*	*37*
40-49 years	3	1	3	2	2	1	12 *(13)*	*20*
50 years +	1	2	1	4	1	0	9 *(10)*	*12*
Race								
Caucasian	14	9	23	14	13	9	82 *(89)*	*77*
Aboriginal	2	2	1	0	2	1	8 *(9)*	*16*
Black	0	0	0	0	2	1	3 *(3)*	*7*
Marital Status								
Single	11	7	18	7	13	9	65 *(70)*	*57*
Common-law	4	3	5	4	3	1	20 *(22)*	*30*
Married	1	1	1	3	1	1	8 *(9)*	*12*
Sentence								
2-5 years	5	4	8	4	10	3	34 *(37)*	*41*
6-9 years	2	4	9	4	2	3	24 *(26)*	*29*
10+ years	3	0	0	2	2	0	7 *(8)*	*12*
Life or indeterminate	6	3	7	4	3	5	28 *(30)*	*18*
Security Level								
Maximum	4	3	7	3	3	4	24 *(26)*	*13*
Medium	12	7	16	9	13	7	64 *(69)*	*66*
Minimum	0	1	1	2	1	0	5 *(5)*	*21*

[1] As of October 31, 1997

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Minimum	0	1	1	2	1	0	5 *(5)*	*21*

[1] As of October 31, 1997

1996-97 IN REVIEW

Eleven inmates committed suicide in federal penitentiary between April 1 1996 and March 31 1997. One of these deaths is thought to have been the result of an autoerotic asphyxiation[2]. Even though there is no final conclusion on the exact cause of death for this individual, he will be counted in our statistics. The incidence rate of inmate suicide in 1996-97 (7.1 per 10 000 offenders) was the lowest since CSC first began publishing retrospective reports. All suicides were committed by males between the ages of 20 and 43 (mean=29.6, Std. Dev.=6.3) and the majority were committed in the Québec region. Table 5 presents other demographic information for these individuals.

Table 5. Demographic information on offenders who committed suicide in 1996-97 (N=11).

Region		
	Québec	5
	Ontario	4
	Atlantic	1
	Pacific	1
	Prairies	0
Race		
	Caucasian	9
	Aboriginal	1
	Black	1
Marital Status		
	Single	9
	Married	1
	Common-law	1
Security Level		
	Medium	7
	Maximum	4
	Minimum	0
Education Level		
	Some High School	7
	Grade 1 to 8	2
	High School Diploma	2

Criminal history and sentencing information

[2] Autoerotic asphyxiation involves sexual stimulation combined with oxygen deprivation by means of a noose, ligature, plastic bag, mask, chemical, or chest compression, but allows him/herself the opportunity to escape asphyxiation prior to the loss of consciousness. Due to equipment failures, errors in placement of the noose or ligature, or other mistakes, accidental deaths sometimes occur (Uva, 1995).

Perhaps the most striking feature of those who committed suicide this fiscal year was the violent nature of their offenses. Many of the crimes committed by these individuals received considerable media attention. Five of the eleven inmates had a history of violent sexual offending and five offenders from this sample were serving either a life or indeterminate sentence. One inmate had received a Dangerous Offender designation while another was being processed as such.

Table 6. Criminal history of offenders who committed suicide in 1996-97 (N=11).

Current offence		
	Sex offence	4
	Second degree murder	3
	Assault	1
	Armed Robbery	1
	Break and Enter/Theft	2
Number of offenders with prior provincial incarcerations		6
Number of offenders with prior federal incarcerations		2
Number of offenders with major institutional offences		6
Number of offenders with minor institutional offences		7
Average # of months incarcerated since adulthood[3]		76
Average # of months served - current sentence		50

Case needs analysis

Much like the general population of offenders, the inmates who committed suicide this year suffered from a variety of problems. Most of the offenders had histories of alcohol and drug abuse and many were physically or sexually abused as children (Table 7).

[3] Adulthood is defined here as the time at which the individual would have been prosecuted as an adult.

Table 7. Case needs of offenders who committed suicide in 1996-97 (N=11).

EMPLOYMENT		
	Never employed or generally unemployed	11
	Lacked a skill/trade/profession	10
	Had psychological problems that interfered with employability	4
	Had physical problems that interfered with employability	3
FAMILY BACKGROUND		
	Suffered physical abuse as a child	5
	Witnessed spousal abuse or other family violence as a child	4
	Parents divorced/separated	3
	Suffered sexual abuse as a child	2
SUBSTANCE ABUSE		
	Had alcohol related problem	8
	Had drug related problem	8
ASSOCIATES		
	Had many criminal associates in the community	9

Psychological/psychiatric background

Ten of the eleven inmates in question had received some type of psychological or psychiatric assessment in their past. At least four inmates had been diagnosed with a personality disorder and four individuals in this sample had previously been prescribed psychoactive medication. Interestingly, eight inmates from this sample had a history of suicide attempts and six had previously engaged in self-injury (Table 8).

Table 8. Mental health background of offenders who committed suicide in 1996-97 (N=11).

Previous suicide attempts	8
Previous self injury	6
Previous mental health program participation	7
Seeing a psychologist/psychiatrist prior to the suicide	8
Documented history of suicidal ideation	4
Diagnosed with personality disorder	4
History of psychoactive medication	4
History of depression	6

Circumstances of the suicide

Except for one notable exception (drug overdose), all offenders in this sample died of asphyxiation as a result of hanging (Table 9). All but one of these suicides were committed in the inmate's cell. While it is always difficult to infer motives from these deaths, the Boards of Investigation often pointed to stressors generated within the institution itself as being main contributors to the act (e.g. pressure from other inmates because of the nature of the victim's offence or significant drug debts).

Table 9. Circumstances of the suicides committed in 1996-97 (N=11).

Method		
	Hanging	10
	Drug overdose	1
Location		
	In cell	10
	Shower facilities	1
Suspected precipitant		
	Inmate pressure	5
	Drug debts	2
	Denial of conditional release	1
	Failure on conditional release	1
Suicide Note		4
Awaiting transfer		2
In involuntary administrative segregation		1
In disciplinary segregation		0
In voluntary administrative segregation		3

CASE STUDIES

A short profile of each suicide committed during the 1996-97 fiscal year is presented in this section of the report. There are three parts to each of these case studies. The first gives background information on the incident and presents a list of variables that have been found to correlate with inmate suicide (as per the literature review in Appendix A). A checkmark is placed next to the variable to indicate whether or not the inmate in question possessed that characteristic. The intent here is to frame our discussions of any particular case with recent literature in the area. It also serves as a starting point for future research projects and retrospective reports.

The next section is a brief narrative of the case itself based on the report from the Board of Investigation. The purpose of this section is to provide the reader with context when examining the final part of the case study, which is the recommendations made by the Board.

In general, each institution is responsible for developing an action plan for every Board recommendation. Some recommendations have significant impacts and are subsequently adopted at a national level. Interestingly, three Boards of Investigations this year did not submit any recommendations.

It should be noted that the author has avoided making inferences about these individuals. For example, there is a temptation to conclude that inmates who commit suicide suffer from hopelessness or depression when this is not always the case. Therefore, unless it is explicitly stated in the Board of Investigation Report, no conclusion about any particular variable will be made.

OFFENDER 1

Background

Method	Hanging
Institution	Archambault
Arrival at institution (most recent)	January 31, 1996
Current offences	Break and Enter, Conspiracy to Break and Enter with Intent, Theft over $1000, Possession of Break-In Instruments, Possession of Narcotics

Predictors

ACTUARIAL RISK FACTORS		
	Age	29
	Marital status	Single
	Sentence length	2 years
	Time served in sentence	8 mos., 8 dys.

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour	√		
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent	√		
	Suicide plan	√		
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs		√	
	Psychotic symptoms		√	
	Physical isolation	√		
	Psychosocial isolation	√		

Narrative

This inmate experienced a number of difficulties living in the regular population of the institution. He had enemies among his fellow inmates, particularly among inmates associated with motorcycle gangs, and appeared to live in constant fear for his life. There were numerous self-inflicted injuries and suicide attempts prior to his death. Many of these behaviours were perceived as manipulative and thought to be strategies to avoid the pressure from other inmates.

His most recent suicide attempt occurred four days prior to his death. He was treated in hospital and eventually returned to a detention cell (non-camera equipped). A memorandum was written to detention officers asking that they pay special attention to the inmate given his higher risk to commit suicide.

The Board of Investigation found that interventions undertaken after his previous suicide attempts were poorly conducted. The surveillance of this inmate during his placement in detention was considered inappropriate. The Board also felt that there had been a lack of continuity and of uniformity in the way information was transmitted between staff.

From the time that the inmate was found, the emergency interventions undertaken by the institution's personnel showed a high level of diligence and professionalism.

Critical Incident Stress Management was offered to all employees involved in the incident but was apparently refused. No such intervention was offered to inmates.

Recommendations

- that management ensure adherence to Standing Orders;
- that a complete psychological assessment be conducted on offenders with recent suicide attempts;
- that management review the means of communication between staff and ensure that these means are efficient, understood, and implemented; and
- that management ensure the appropriate use of cells with surveillance cameras.

OFFENDER 2

Background

Method	Hanging
Institution	Warkworth
Arrival at institution (most recent)	June 10, 1993
Current offences	Assault with a Weapon (sexually motivated)

Predictors

ACTUARIAL RISK FACTORS		
	Age	32
	Marital status	Single
	Sentence length	Indeterminate (D.O.)
	Time served (years, months, days)	2/10/12

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour	√		
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent	√		
	Suicide plan	√		
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs		√	
	Psychotic symptoms		√	
	Physical isolation		√	
	Psychosocial isolation		√	

Narrative

This inmate's criminal history consists of six convictions for sexual or sexually-related offences. In all, including the offences that came to official notice, he recalled sexually assaulting twenty-one victims. Plagued by feelings of depression for most of his life, he had actively attempted suicide on at least one previous occasion, and had prepared himself for two other attempts. Some felt that the inmate could no longer live with his deviant sexual arousal and the emotional turmoil that it caused.

The offender secured two ropes made up of boot lace around a sprinkler head that protruded laterally out of the cell wall above the cell door. A suicide note was left behind.

The Board of Investigation was satisfied that staff at the institution reacted appropriately to the inmate's previous suicidal behaviour and that there were no pre-indicators to this suicide. The staff responded quickly and professionally to the incident. Critical Incident Stress Management was carried out with staff but apparently not with offenders. Inmates who were friends of the victim felt that they could have been informed of his death much earlier.

The Board was concerned about the misinformed views expressed by some inmates regarding the suicide watch practice at this institution. When an inmate is judged to be in a suicide crisis, he is placed in a barren observation cell in which he is observed every 15 minutes until the crisis is judged to have passed. Counseling is also carried out. Due to space and fiscal constraints, the suicide observation cell was in the dissociation/segregation area of the institution. This leads some inmates to believe that an active suicide watch during a crisis was actually a punishment.

Recommendations

- investigate whether the sprinkler head performs to specifications. The model used in this institution should not have been able to support the weight of this inmate;

- that the Critical Incident Stress Management program be improved:

    (i) develop a staff group debriefing that would assist two different groups of staff affected by the suicide; the first group being those staff who had to deal with the trauma of the incident and the second group being those staff who considered themselves friends, counselors or in a position of trust with the inmate.

    (ii) develop a process to quickly identify inmate friends of the inmate involved in the suicide so that they may be offered assistance in coping with their emotional stress.

- improve the suicide prevention program, and awareness of it:

  (i) communication sessions for the inmate population on what the suicide prevention program consists of and why, with particular attention paid to informing the inmates on what an active suicide watch is and why it is carried out the way it is.

  (ii) communication sessions for staff on the suicide prevention program, and the degree of suicidal ideation in the inmate population.

  (iii) when future construction and staff complement changes are planned, consideration be given to moving the suicide observation cell out of the Dissociation/Segregation area.

  (iv) assessing various suicide prevention volunteer and peer help programs being carried out in other Correctional Service of Canada institutions with the goal of initiating one at Warkworth Institution.

OFFENDER 3

Background

Method	Hanging
Institution	Leclerc
Arrival at institution (most recent)	April 24, 1994
Current offences	Armed Robbery, Conspire to Commit, Use of Firearm

Predictors

ACTUARIAL RISK FACTORS		
	Age	35
	Marital status	Single
	Sentence length	6 years
	Time served (years/months/days)	2/09/29

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)		√	
	History of impulsive behaviour		√	
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan		√	
	Hopelessness			√
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms		√	
	Current problem with alcohol or drugs			√
	Psychotic symptoms		√	
	Physical isolation		√	
	Psychosocial isolation	√		

Narrative

This offender was serving his second federal sentence and was actively involved in the institution's drug trade. Some hypothesized that it was his numerous drug debts that drove him to suicide. He was in fact a regular user of hard drugs while at Leclerc (heroin). There were no pre-indicators, nor any documented history of suicide attempts or self-injury.

The Board of Investigation was concerned that the extent of the offender's drug problem was not well understood by staff. In addition, it was noted that the Deister system was not working properly. Apparently the equipment had been vandalized over the last number of months and the institution was doing all it could to remedy the problem. While not considered to have had an impact on the final demise of the subject, the Board could not verify the time and frequency of every round conducted by the correctional officers. The Board also noted that while the correctional officers involved in the incident were able to leave the institution after the immediate crisis had passed, the nurse on duty could not. Apparently, a replacement could not be found at the time and the employee had to complete the entire shift.

The staff's response to the crisis was found to be efficient and timely. Critical Incident Stress Management was conducted with staff involved in the crisis and the institutional psychologist visited inmates who had worked with the deceased.

Recommendations

- ensure that the institution's urinalysis coordinator share his or her observations with the case management team;
- ensure that the Deister system is fully functional;
- establish a staffing strategy which allows employees who are affected by a critical incident to leave the workplace (i.e. that replacements be made available);
- that management ensure that all staff involved in such incidents receive support and appropriate referrals; and
- that the institution's Standing Orders be well understood by all staff.

OFFENDER 4

Background

Method	Hanging
Institution	Mountain
Arrival at institution (most recent)	November 13, 1996
Current offences	First Degree Murder, Sexual Assault

Predictors

ACTUARIAL RISK FACTORS		
	Age	20
	Marital status	Single
	Sentence length	Life
	Time served (years/months/days)	2/09/27

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history	√		
	History of alcohol or drug abuse		√	
	Prior suicide attempt(s)	√		
	History of impulsive behaviour	√		
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan		√	
	Hopelessness		√	
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping			√
	Depressive symptoms		√	
	Current problem with alcohol or drugs		√	
	Psychotic symptoms		√	
	Physical isolation		√	
	Psychosocial isolation		√	

Narrative

The subject in this high profile case was serving a life sentence for sexually assaulting and murdering a six-year-old girl. His suicidal history, which was all self-report, consisted of three attempts including two in a Youth Detention Centre. Previous psychological assessments described the subject's unstable home situation as having contributed to adjustment problems, low self-esteem, excessive anxiety, impulsiveness, and communication difficulties.

The Board of Investigation could not determine the motive for this death and presented three hypotheses: intentional suicide, unintentional suicide - hoping to be rescued, and autoerotic asphyxiation. Regardless of the motive, it was found that security and nursing staff responded appropriately and professionally to the emergency situation. Documentation completed by security staff complied with established requirements. Concern was expressed about the Health Services Centre, which was usually staffed with only one nurse during the evening shift. This apparently makes it difficult for the nurse to respond to an emergency without an escort to assist in the carrying of the emergency equipment. Nursing staff was also left out of the Critical Incident Stress debriefing because of a miscommunication but a separate debriefing session was offered at a later time. There was also concern that phone numbers for institutional psychology staff were not available at the Central Control for ready access when Critical Incident Stress Management was required.

Recommendations

- that staff be commended for quick and professional action;
- that nursing policies and procedures be developed by the Health Services Unit to guide the practice of nurses and to comply with the Standards of Professional Practice as outlined by the provincial regulatory body. These should include the necessity of documenting nursing actions when completing individual Officer's Statements/Observation reports;
- that in emergency situations requiring nursing presence, an officer be detailed to respond to the Health Services Unit to escort the nurse to the emergency and to assist with transporting any necessary equipment; and
- that telephone numbers for all staff be readily available in Central Control for emergency access.

OFFENDER 5

Background

Method	Hanging
Institution	Regional Treatment Centre, Ontario
Arrival at institution (most recent)	April 07, 1995
Current offences	Sexual Assault

Predictors

ACTUARIAL RISK FACTORS		
	Age	43
	Marital status	Single
	Sentence length	5 years
	Time served (years/months/days)	2/07/19

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history	√		
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)		√	
	History of impulsive behaviour	√		
	Family history of suicide			√

CLINICAL RISK FACTORS		**Y**	**N**	**Unk**
	Suicidal ideation and suicidal intent		√	
	Suicide plan		√	
	Hopelessness			√
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs		√	
	Psychotic symptoms	√		
	Physical isolation		√	
	Psychosocial isolation	√		

Narrative

The offender was serving a first federal offence for sexual assault. He was schizophrenic and treated under a Treatment Order at the Regional Treatment Centre in Ontario (the Regional Treatment Center is a Schedule 1 Mental Health facility). There were no pre-indicators and no documented history of suicidal behaviour or self-injury. In the days prior to his death however, the offender had conversations with his Case Management Officer about his Detention Review by the National Parole Board. The subject interacted with and was observed by three different staff in the hour prior to his suicide.

Critical Incident Stress Management was conducted, however, it was not in accordance with CSC policy and procedures and did not address the needs of staff members involved in the incident.

In examining each of the other mandated areas, the Board of Investigation determined that the incident was handled in a professional, effective and efficient manner.

Recommendations

- that the institution obtain a manual suction device for use during medical emergencies;

- that correctional staff have the necessary equipment to communicate with staff in the Unit Office when confronted with an emergency in the unit;

- ensure that Case Management Officers communicate formally with front line staff subsequent to discussing disturbing, or potentially upsetting information with an offender;

- that the Regional Critical Incident Stress Management Committee review the service provided following this incident and advise the Critical Incident Stress Management Team Leader of possible improvements; and

- that management formally acknowledge staff involved in the incident for their professionalism and efficiency.

OFFENDER 6

Background

Method	Drug overdose
Institution	Millhaven
Arrival at institution (most recent)	November 16, 1994
Current offences	Sexual Assault, Forcible Confinement

Predictors

ACTUARIAL RISK FACTORS		
	Age	21
	Marital status	Single
	Sentence length	8 years
	Time served (years/months/days)	2/05/05

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history	√		
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour			√
	Family history of suicide			√

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent	√		
	Suicide plan	√		
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs			√
	Psychotic symptoms		√	
	Physical isolation	√		
	Psychosocial isolation	√		

Narrative

The above inmate had been transferred to Millhaven institution as a result of a violent crime against a staff member. He was awaiting transfer to the Special Handling Unit in Québec but was kept at Millhaven until the completion of his trial. Less than twelve hours before his death, the inmate was convicted of four additional offences including Forcible Confinement and Sexual Assault. The Crown intended to introduce an application to have him declared a Dangerous Offender.

The inmate was socially isolated and frequently threatened to harm himself or others. He was in Segregation on a suicide watch for virtually all of the 21 months he spent at Millhaven. In the months prior to his death, he began to hoard and hide most of the medication he was receiving. Unfortunately, the suicide watch had little practical effect upon his lifestyle compared to other inmates who were not on a similar watch. The Board of investigation found that the administration of his medication was not well controlled, that he enjoyed access to all cell effects, even those that might have been seen as having potential to carry out a suicidal intent, that his cell was not searched with any higher degree of frequency, and that the officers did not increase the number of rounds per day where they observed him in his cell. He died of a pulmonary edema consistent with a drug overdose.

The Board felt that the offender's death was a deliberate act of aggression and not likely related to feelings of depression. The suicide note he left placed him in a victim role whereby he blamed the professionals involved with him for not meeting his needs.

Recommendations

- amend the institution's Standing Order on suicide to reflect a strategic and practical prevention strategy derived from a sound risk assessment;

- that on a case by case basis, inmates be actively considered for transfer to the Special Handling Unit as soon as possible after approval is received and particularly when lengthy court proceedings are anticipated. When such a transfer cannot be executed, assessment and provision of appropriate programming should begin without delay;

- that the Standing Order on Drugs and Medical Supplies be updated to reflect the new distribution process in both the Segregation Unit and the institution in general;

- that a comprehensive search plan be developed in accordance with the Corrections and Conditional Release Act. The plan should address the unique needs of an inmate on suicide watch and specify performance expectations of staff. The plan should be evaluated at least annually;

- all staff who have a need to know must get information about inmates in Segregation and on suicide watch in a timely manner. The Correctional Officer II in the Segregation Unit at Millhaven Institution should be a member of the Mental Health Team; and

- that the Standing Order on Post Trauma counseling be rewritten to conform with current CSC policy and practices.

OFFENDER 7

Background

Method	Hanging
Institution	Archambault
Arrival at institution (most recent)	September 16, 1996
Current offences	Assault, Use of Force, Threats of violence and Fail to Comply

Predictors

ACTUARIAL RISK FACTORS		
	Age	29
	Marital status	Married
	Sentence length	2 years
	Time served (years/months/days)	00/01/27

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history	√		
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour			√
	Family history of suicide			√

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan			√
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs			√
	Psychotic symptoms	√		
	Physical isolation		√	
	Psychosocial isolation	√		

Narrative

This offender was serving a two year sentence for assaults committed against his wife. He was only two months into his sentence when staff found him hanging from the handle of his cell's window.

The most notable feature in this case was the severe language barrier between the inmate and staff. As an Aboriginal from a remote community in northern Québec, he spoke no French and practically no English. Consequently, very little was known about the offender's state of mental health other than his recent suicide attempt a few days prior to his death.

The Board of Investigation felt that policies relating to Aboriginal needs were perhaps not well understood by staff. Otherwise, the Board noted a professional and effective response to the incident. Critical Incident Stress Management was offered to staff but was declined. It does not appear that it was offered to inmates.

Recommendations

- that procedures relating to interpreters be established in institutions where there is a need to do so;

- that requests for interpreters be made in the very first week of arrival at the Regional Reception Centre;

- that management clearly define the role of Aboriginal Liaison Officers and their relationship with case management staff; and

- that management highlight the very effective response by security and health services staff during this incident.

OFFENDER 8

Background

Method	Hanging
Institution	Springhill
Arrival at institution (most recent)	July 19, 1996
Current offences	Second Degree Murder

Predictors

ACTUARIAL RISK FACTORS		
	Age	30
	Marital status	Single
	Sentence length	Life
	Time served (years/months/days)	11/09/09

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour			√
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan		√	
	Hopelessness		√	
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms		√	
	Current problem with alcohol or drugs			√
	Psychotic symptoms		√	
	Physical isolation		√	
	Psychosocial isolation		√	

Narrative

The inmate was serving a life sentence for a Second Degree Murder he committed at the age of 18. He was almost 12 years into his sentence when staff found him hanging from the cupboard in his cell.

The Board of Investigation made note of the offender's repeated failures on conditional release. Following his third unsuccessful attempt at Day Parole (substance abuse), it appears that he may have felt that his support network was shrinking. He applied for a transfer to another institution, perhaps looking for a new beginning but was denied. There may have been some family unrest as well because the subject's family did not want him to return to his home province. He was determined to go there to be closer to his son and inasmuch as CSC supported him with this, his failed urinalysis had jeopardized his placement in a halfway house.

Despite all this, everyone interviewed by the Board of Investigation reported that they were surprised when informed of the inmate's suicide. There were no pre-indicators and no clinical signs of depression or hopelessness. The offender left a suicide note naming individuals whom he wanted informed of his demise. In the note, he blamed CSC for many of the problems that he faced.

The Deister electronic printouts studied by the Board of Investigation indicated a regular sequence of patrolling the ranges in the unit, rather that a random one. Inmates thus would be able to anticipate when the next check of their cell was due.

A debriefing session was held for staff involved in the incident but apparently none was offered to inmates.

Recommendations

- none

OFFENDER 9

Background

Method	Hanging
Institution	Port Cartier
Arrival at institution (most recent)	July 09, 1996
Current offences	Sexual Assault, Use of Firearm, Forcible Confinement

Predictors

ACTUARIAL RISK FACTORS		
	Age	29
	Marital status	Single
	Sentence length	7 years, 6 months
	Time served (years/months/days)	2/01/08

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour			√
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent	√		
	Suicide plan		√	
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms	√		
	Current problem with alcohol or drugs		√	
	Psychotic symptoms		√	
	Physical isolation	√		
	Psychosocial isolation	√		

Narrative

The subject was serving a seven year, six month sentence for Sexual Assault and the Use of a Firearm. He had been transferred to this maximum security facility at his own request because of difficulties integrating into the general population at the Regional Reception Centre and then again at Cowansville Institution. These problems followed him at Port Cartier where he was placed in administrative segregation on four different occasions, two at his own request. The inmate often related that he feared other inmates and that his personal safety was always at risk. He was described as a generally anxious individual who was not accepted by other inmates. File information indicates that his psychosocial isolation and inability to cope led to various forms of self-injury while incarcerated (hanging, slashing, burning, head banging). He also attempted suicide on two occasions prior to his federal incarceration. While there were no obvious pre-indicators, the offender did refuse a number of meals in the days leading to his suicide. He was found hanging from a sheet that he had secured onto the protective grill of his cell's fire detector.

The Board of Investigation noted staff's awareness and responsiveness to the inmate's various needs. His Case Management Officer met with him regularly and medical staff attended his cell daily during his lengthy stays in segregation. Security staff also appeared to have been sensitive to the offender's problems. The Board found that rounds were conducted as per policy requirements in the hours preceding his death. The Board also saw the emergency response that was conducted afterwards as highly effective.

A Critical Incident Stress Management defusing session was held with staff involved in the crisis and no follow-up was thought to be necessary. However, it does not appear that this was offered to inmates.

Recommendations

- none

OFFENDER 10

Background

Method	Hanging
Institution	Leclerc
Arrival at institution (most recent)	April 20, 1994
Current offences	Second Degree Murder

Predictors

ACTUARIAL RISK FACTORS		
	Age	32
	Marital status	Common-law
	Sentence length	Life
	Time served (years/months/days)	12/01/13

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history		√	
	History of alcohol or drug abuse	√		
	Prior suicide attempt(s)	√		
	History of impulsive behaviour	√		
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan		√	
	Hopelessness	√		
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms		√	
	Current problem with alcohol or drugs		√	
	Psychotic symptoms		√	
	Physical isolation		√	
	Psychosocial isolation		√	

Narrative

The offender was serving a life sentence for Second Degree murder. He was found hanging from a nylon rope that he had secured onto his cell's ventilation grill.

There were a number of issues that the Board felt could have contributed to the subject's decision to commit suicide. Firstly, his relationship with his common-law partner was fairly unstable. Also, some had reported that the subject had accumulated significant drug debts within the institution. Finally, the inmate feared that his recent collaboration with preventive security could threaten his safety and eventually lead to protective custody status; something he apparently could not have accepted.

Those interviewed during the investigation were all surprised by the offender's decision to commit suicide. However, it should be noted that his partner advised staff that she was concerned about the offender's state of mind on the day prior to his death. This information was smartly transmitted to front line staff who worked in the offender's unit. Unfortunately, the information did not make its way to staff who took over on the next shift. The Board of Investigation also learned that the electronic monitoring system, which records correctional officer rounds, was also malfunctioning but this apparently would not have changed the final outcome.

The Board was satisfied with staff's response to the emergency. Critical Incident Stress Management was conducted with both staff and affected inmates.

Recommendations

- none

OFFENDER 11

Background

Method	Hanging
Institution	Kingston Penitentiary
Arrival at institution (most recent)	April 20, 1994
Current offences	Second Degree Murder

Predictors

ACTUARIAL RISK FACTORS		
	Age	26
	Marital status	Single
	Sentence length	Life
	Time served (years/months/days)	6/00/05

HISTORICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Psychiatric history			√
	History of alcohol or drug abuse		√	
	Prior suicide attempt(s)		√	
	History of impulsive behaviour	√		
	Family history of suicide		√	

CLINICAL RISK FACTORS		**Y**	**N**	**Unk.**
	Suicidal ideation and suicidal intent		√	
	Suicide plan			√
	Hopelessness		√	
	Sudden change in psychological functioning		√	
	Stress, vulnerability and poor coping	√		
	Depressive symptoms			√
	Current problem with alcohol or drugs		√	
	Psychotic symptoms			√
	Physical isolation	√		
	Psychosocial isolation	√		

Narrative

The offender was serving a life sentence for murder and was subsequently convicted of assaulting his cell partner. There was no prior history of suicide and there were no pre-indicators of suicidal intent. However, a staff psychologist assessed the subject in October, 1993 after it was reported that he "had handed in a noose to security and said that he had been thinking of killing himself". At the time, the psychologist noted that there was no history of suicide and that the gesture of handing in a noose could have been an attention-seeking behaviour. In November 1996, the offender slashed his left wrist with a razor blade. The laceration was superficial to moderate in severity and did not require stitching. He indicated to a psychologist that "he had no intention to hurt himself" but that he had slashed to change cells. A few months later, he was found hanging from his cell bars.

File information reveals that the offender believed he was muscled by other inmates for money and consequently, spent a lot of time in voluntary administrative segregation. This does not appear to have been the motive for suicide however. Unfortunately, a complete psychological assessment could not be found on the psychology file that was given to the Board of Investigation.

Correctional staff patrolled the range shortly before the inmate's death but did not record this information due to the malfunctioning Deister system. Moreover, the Board found that the Deister system was not being downloaded regularly by supervisory staff to ensure compliance. Despite this, the Board of Investigation was confident that patrols were conducted as required at the time of the inmate's death.

Critical Incident Stress Management debriefings were held with staff but there is no mention of it having been conducted with affected inmates.

Recommendations

- none

DISCUSSION OF RECOMMENDATIONS

The final section of this report will provide an overview of recommendations made by this year's Boards of Investigation. This section will also comment on recommendations that have been made regularly in the past and appear to be recurring themes.

In general, each institution is responsible for developing an action plan for every Board recommendation. Some recommendations have significant impacts and are subsequently adopted at a national level. Interestingly, three Boards of Investigations this year did not submit any recommendations.

It is useful to group recommendations in two broad categories: primary prevention strategies, and secondary prevention strategies. Primary prevention strategies consider factors in the environment that could affect the overall incidence of suicide in prisons. These include policies and procedures, staffing practices, and the physical layout/design of prisons. These interventions can be costly, especially if they include reconstruction, increased staffing levels, or major changes to longstanding policies and procedures. Secondary prevention strategies focus on ways to deal with offenders who may be at a high risk to commit suicide. Examples of secondary prevention strategies include counseling, peer support groups, and inmate observation aides.

Primary prevention

A. Policy/procedure

Boards of Investigation have often noted a lack of compliance with, or knowledge of, existing Commissioner's Directives, Regional Instructions, or Institutional Standing Orders. Adherence to Commissioner's Directive (CD) 257 - Critical Incident Stress Management (CISM) is a noteworthy example. CISM is a formal intervention undertaken with staff and inmates by a mental health professional to lessen the impact of distressing incidents and events. It also educates victims on the prevention and effects of post traumatic stress disorders. Unfortunately, one of the most frequent observations has been the lack of compliance with CD 257. CISM was provided according to policy in less than one half of all inmate suicides (April 1,1992 to March 31, 1997). It was not provided at all in approximately 20% of the cases.

In fewer instances, a Board of Investigation will suggest that CSC develop new policies and procedures or improve those that already exist. In one institution this year, there was a recommendation that nursing policies and procedures be reviewed so as to comply with the Standards of Professional Practice outlined by the province's regulatory body. In another institution, it was recommended that a comprehensive cell search plan be developed in accordance with the Corrections and Conditional Release Act. In Québec, a need to develop procedures relating to interpreters (for non-English or French speaking inmates) was noted and in Ontario, it was suggested that a Standing Order on Drugs and Medical Supplies be updated to reflect a new distribution process.

Last year's retrospective report recommended that CSC invite an external suicide expert to review its suicide policies, practices, training materials, and investigation reports. CSC's Health Services Division has been consulting with such an individual and is expecting feedback before the end of this fiscal year. A report will be produced and forwarded to CSC senior management for further consideration and action.

B. Improving communication/information sharing

Communication breakdowns and information sharing difficulties have often been a main focus during investigations. These problems were sometimes the result of poor case documentation, the inaccessibility of electronic reports, or the failure to properly notify staff of relevant information (e.g. during shift changes).

Many recommendations made this year revolved around this theme. In one case, the Board of Investigation proposed that Case Management Officers should communicate formally with front line staff subsequent to discussing potentially upsetting information with an offender. In Ontario, it was suggested that Correctional Officer IIs from segregation units be made members of the institution's mental health team. The importance of having adequate communication between an institution's urinalysis coordinator and the case management team was highlighted in a Québec region investigation. Two other recommendations are worth mentioning here. In one instance, the Board recommended that communication equipment be made available to correctional staff so that they can talk directly to staff members in the Unit Office when confronted with an emergency. In another, it was suggested that the telephone numbers for all staff be made readily available for emergency access (e.g. to have a psychologist available to provide Critical Incident Stress Management).

While it appears that progress has been made in recent years, it is clear that there are always additional ways to improve communication. This also holds true for communication between staff and inmates. One Board of Investigation this year recommended that inmates be made fully aware of what suicide prevention programs consist of and why active suicide watches are carried out the way they are.

C. Prison structure/design, accessibility to emergency equipment, and quality of the response

A number of Investigations have looked at inmates' physical environments as possible risk factors for self-inflicted death and Boards have often looked for ways to improve the safety of prisons. For instance, because suicidal inmates are most likely to hang themselves, it is important that their cells be designed so as to minimize their chances of success. A good case in point this year was a particular institution's sprinkler head that, according to the manufacturer, should not have been able to support the weight of an inmate. Greater and more effective use of camera-equipped cells was outlined in one of this year's investigations while in another case, the Board suggested that suicide observation cells be moved out of dissociation/segregation areas. A few institutions

have had defective electronic monitoring systems such that it was impossible for the Board to verify the frequency of Correctional Officer rounds.

In previous years, recommendations were sometimes made regarding the inaccessibility of medical/emergency equipment or the lack of adequate training for staff (e.g. cardiopulmonary resuscitation). This was not the case this year although in one incident, it was felt that there should be one Correctional Officer assigned to the Health Services Unit. This individual would assist nursing staff with transporting any necessary equipment to an inmate's cell. In a related matter, one Board of Investigation recommended that an institution purchase a manual suction device for emergency situations.

As was seen in this year's case studies, Boards of Investigation typically commended staff for quick, effective, and professional responses to crises. In fact, a number of Boards recommended that management formally acknowledge certain staff members for their excellent work in these incidents. Judging by their comments, it would appear that CSC employees are well prepared for emergencies and that staff training has generally been successful.

Secondary prevention

A. Identifying high risk individuals

The initial phase of incarceration is considered by many to be the most dangerous time for committing suicide. This sentiment has been in reflected in prior retrospective reports and was again mentioned this year by one Board of Investigation. Members suggested that all inmates be assessed for mental health problems and suicide within 24 hours of their arrival at an institution. Another Board of Investigation recommended that a complete psychological assessment be conducted on all individuals with recent suicide attempts.

CSC continues to improve its methods of identifying those who are most vulnerable to self-injury and suicide at the earliest possible moment in their sentence. The Offender Intake Assessment (OIA) now identifies inmates with specific mental health needs and flags those who are most prone to suicidal behaviour. What is not well known, at least at a national level, is what type of interventions these offenders receive over the course of their sentence. CSC has therefore initiated an outcome study of individuals who have attempted suicide in prison.

B. Intervention

Much has been said about how to intervene with the suicidal inmate. Some have proposed special observation facilities, including 24-hour, one-on-one surveillance while others have described procedures to bring in family and friends of the inmate in times of crisis. Some non-Canadian jurisdictions have made use of "inmate observation aides" to help custodial staff monitor an inmate's behaviour. Last year's retrospective report specifically recommended the implementation of peer support projects in all institutions.

Unfortunately, there have been few rigorous evaluations of these programs. There is some evidence in the substance abuse literature that creating a support network of individuals with similar backgrounds and problems can be as effective as professional intervention. While this bodes well for peer support groups, CSC will proceed cautiously. It is well known that formal prison groups can be taken over with psychopathic individuals who may exploit those they are mandated to help.

1996-1997 recommendations

1. That a select number peer support groups (with clearly defined selection criteria) be established in various CSC institutions and that prior to their creation, an evaluation protocol be established.

2. That CSC study the long-term effects of inmate suicide on staff that have been affected by such an event.

3. That CSC's research agenda include a study of the differences between suicide attempters and those who successfully commit suicide.

CONCLUSION

Self-inflicted death continues to occur in federal penitentiary but recently at a lower rate than in previous years. While it is extremely difficult to explain or draw meaning from the yearly variations of such rare events, (i.e. 11 inmates out of approximately 14 000 committed suicide in 1996-97) it is hoped that CSC's efforts to refine policy, improve procedures, and educate staff have contributed at least in part to the recent decline in suicide. The ongoing accumulation of data and subsequent publication of retrospective reports may help determine whether or not there is an emerging trend showing a decline in the rate of suicide.

This is not to suggest that collecting statistics on deaths in custody actually solves the problem. At the very least however, reports such as these can highlight where improvements can be made and where best practices should be adopted. Moreover, the exercise of monitoring incidence rates will help alert the organization to unexpected increases in suicide or specific causes of death that may be of particular concern. Finally, the systematic collection of information can help identify recurring themes and ongoing problems such as a lack of compliance to policy and procedure, lack of communication between staff, defective equipment, and unsafe physical environments within CSC institutions.

It would be unfair however, to conclude that CSC has failed in its duty of care whenever a suicide occurs. It is sometimes the case that everything reasonably possible has been done to help and monitor an inmate yet the inmate still commits suicide. Fortunately, "such unambivalent suicidality is the exception to the rule" (Schwartz et al., 1975). Accordingly, CSC will continue to plan interventions based on the assessment of risk. Risk assessment and management is not about certainty however. Rather, it is about the estimation of probability of an event occurring. The issue therefore is how to improve these estimations and then implementing effective strategies. In this regard, the review of the literature in Appendix A should be useful for staff charged with assessing an inmate's risk of committing suicide and for those required to observe subsequent behaviour.

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Action on previous recommendations

Suicide reports can be used to monitor CSC's progress in meeting previous recommendations. The table presented below outlines the organization's response to prior investigations.

Recommendation	Status
That a training package be developed to assist investigation teams in conducting and writing suicide reports.	A comprehensive investigation package now exists, which incorporates suicide investigation and the writing of suicide reports. It is entitled, "*Guide for the Conduct of Investigations in Correctional Services of Canada*".
That Psychological Reviews be submitted as part of investigation reports.	CSC's Performance Assurance Sector has initiated an informal procedure whereby telephone contact is made with the appropriate region immediately following a suicide. The region is informed of the requirement that a psychologist be part of the investigation team and the requirement that a Psychological Review be submitted with the investigation report.
That the format of the Psychological Review be revised to gather only pertinent information, which can reasonably be obtained post-mortem.	Consultations on the Psychological Review were completed resulting in new Psychological Review guidelines, which have been in use since 1995.
That the Regions identify and train a number of staff to conduct all suicide investigations and Psychological Reviews.	Performance Assurance provides ongoing training in the regions on investigation procedures, which include suicide investigations. Part of the training includes an analysis of suicide case studies.
That a commitment be made to implement the recommendations of the Boards of Investigation as deemed relevant, and that follow up action be reported, recorded and disseminated.	Performance Assurance follows up all recommendations to ensure their implementation where appropriate and feasible. They have implemented a procedure to ensure incomplete actions are "brought forward" once the Investigation Report has been signed off.

That NHQ fund the development of a suicide training infrastructure and that Regions be responsible for its implementation.	This recommendation has been implemented as follows: • staff training standards were approved by CSC's Executive Committee, • training funds were allocated ($100,000), • staff in the Pacific, Prairie, Ontario and Atlantic regions have been trained in the Training of the Trainers "Living Works" suicide prevention course, • the training needs of the Québec region were reviewed and it was mutually agreed by NHQ and the Québec region that it was not necessary to provide the Training of the Trainers course due to the region's active involvement with "Action Suicide Montreal" who provide ongoing suicide training and certification to CSC personnel in the Québec region • front-line staff in need of suicide training were identified in accordance with the approved standards and training by the Trainers in suicide prevention has occurred in several institutions.
That suicide screening at intake take into consideration the inmate's family background; history and current involvement in substance abuse; mental health, especially depression; and HIV/AIDS status. **That NHQ develop a simple reassessment form for suicide screening to be administered face-to-face upon transfer.**	Case Management's suicide risk assessment has been adopted incorporating the risk factors for suicide from the *Retrospective Study*. The suicide risk assessment has become a component of the four-part Offender Management System screening, which also includes mental health, health status, and security.

That suicide prevention and awareness training highlight the need for sensitivity to inmates who have recently received negative responses with respect to transfer, appeal, or parole and to those who have recently transferred or are about to be transferred.	There is an agreement with *Living Works Inc.*, who have developed and are providing CSC's suicide training, to incorporate these aspects into the course curriculum. Copies of the *Retrospective Study* and other relevant CSC documents have been forwarded to *Living Works.* Further, the suicide risk assessment incorporates the finding that those who have been turned down for transfer, appeal, parole or judicial review may be at increased risk for suicide.
That resources be set aside to pilot peer support programs and that consideration be given to evaluating the peer support program at Archambault for potential use elsewhere.	Although no additional financial resources were available to implement peer support programs until 1997, NHQ staff has met with management and inmates at a number of institutions to discuss the implementation of peer support programs. An evaluation framework has been developed for these pilot programs under the direction of Performance Assurance.
That consultations be held with inmates to obtain their input concerning suicide prevention, especially peer support or "inmate suicide watch".	Consultations have occurred with both staff and inmates at a number of institutions regarding potential suicide prevention initiatives with special attention given to the feasibility of peer support programs. Unanimous support for suicide prevention initiatives and peer support was received.
That a Coroner's Report (autopsy/ toxicology) be requested by the Warden in all cases of death in custody. **That the Investigation Team receive toxicology reports for all suicides in which drugs or alcohol were confirmed or suspected of being used.**	Commissioner's Directive 530 has been examined by the Policy Review Task Force and will be amended to reflect these recommendations.

Prisoner Suicide: Literature Review

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The assessment and prediction of suicidal risk constitute a serious and difficult task in any setting. Add to this the challenges that may be presented by a specific population (e.g., youth, Aboriginals) and the task may appear even more complicated. This section outlines the factors relevant in predicting suicidal risk in incarcerated sentenced offenders. These factors listed below are culled from two sources: 1) the research literature which has investigated suicide prediction in general and in the prison population in particular; and, 2) the clinical experience of being a psychologist within CSC institutions. Given the clientele of the Correctional Service of Canada, the present review is focused on sentenced prisoners as opposed to remand or jail inmates. This differentiation is necessary, given the body of research addressing jail suicides which demonstrates that jail suicides have some distinct characteristics (Bonner, 1992; Haycock, 1991; Hayes, 1995a; Lloyd, 1990).

Another necessary distinction is that between the long term prediction and the short term assessment of suicide risk in a prison setting. On a day to day basis, CSC personnel are typically more preoccupied with the short-term assessment and management of suicidal prisoners. It is the real life and death consequences of identifying, assessing and managing such inmates that demands attention and resources. While the long-term prediction of prisoner suicide is also of concern, this issue may be perceived to be policy-related and abstract from the viewpoint of the front line staff member. Indeed, it could be argued that the approaches to short-term versus long-term suicide risk prediction are different. Because short term prediction of suicide involves assessing the immediate crisis of an inmate, the assessment is largely clinical (e.g., presence of depressive features, suicidal ideation and intent) as well as historical (e.g., the inmate's personal and family history of suicide) and actuarial (e.g., the inmate's demographic characteristics) in nature. On the other hand, long term prediction of suicide risk typically involves attempting to identify those people who are at risk for suicide over the long-term. Because such prediction is not related to or informed by an immediate clinical crisis experienced by the inmate, the prediction is heavily weighted by historical and actuarial factors (e.g., age, psychiatric history, family history).

When compared to the general population, a disproportionate number of prisoners commit suicide. This is a consistent phenomenon across countries (Backett, 1987; Burtch & Ericson, 1979; Topp, 1979; Hayes, 1989). Burtch and Ericson (1979) calculated the 1966-1976 suicide rate in Canadian federal penitentiaries to be 95.9 per 100,000. They compared this to 14.2 suicides per 100,000 for non-incarcerated males over the same time period. The Research and Statistics Branch (Correctional Service of Canada, 1992) has calculated the federal prisoner suicide across more recent time periods. After reaching a high of 19.7 suicides per 10,000 (i.e., 197 per 100,000 inmates) during 1984 to 1985, the rate decreased slightly over the next three years and then increased slightly to 13.58 suicides per 10,000 (i.e., 136 per 100,000 inmates) during 1991-1992.

The reasons underlying the relatively higher suicide rate amongst prisoners as compared to the general population have not been definitively isolated. Indeed, this is

one of the essential questions underlying the prisoner suicide research. If the reasons were known, the prediction of prisoner suicide might be more accurate. Few studies explicitly investigate the relative importance of contributing factors to suicide in the prison versus general populations. Among the limited research that exists, Lester's (1995) analyses suggest that, as in the general population, prison suicides may be partially attributable to typical domestic social pressures as measured by marriage, divorce and birth rates. However, Lester's regression analyses suggested that these factors were stronger predictors of suicide in the general population than suicide in the prison population. In another study Lester (1990) compared prison and general population suicides rates, and found a significant positive correlation between overcrowding and prison suicide. However, he correctly cautioned against concluding that there existed a causal relationship based on this correlation.

While Lester's research may offer insight into some factors that distinguish between prison and general populations suicide rates, one drawback to such epidemiological research is the lack of sensitivity to the contribution made by clinical and other non-demographic factors. For instance, it is unlikely that large databases of population statistics contain information about the degree of hopelessness experienced by those who committed suicide. Because the contributing factors to prisoner suicide are conceptualized as consisting of both dynamic (e.g., clinical) and static (e.g., demographic) factors (Liebling, 1992, 1995; Polvi, 1997), it is suggested that researchers attempt to obtain a variety of information about the suicides under scrutiny.

Even in the face of attempts to improve the quality of prisoner suicide research, there are inherent difficulties in the prediction of suicide. One major difficulty resides in the fact that suicide is a relatively infrequent event, and thus is automatically difficult to predict. In addition, a number of relevant factors (e.g., history of substance abuse, age, marital status) are characteristic of a large proportion of the prisoner population, and thus have only limited power in the prediction of suicide. Furthermore, several methodological weaknesses in existing prisoner suicide research (Bonner, 1992; Haycock, 1991; Liebling, 1992; Lloyd, 1990) restrict the degree to which solid conclusions can be drawn from many studies. The descriptive and retrospective nature of most suicide research makes it difficult to establish the causal role of some factors. The general lack of control and comparison groups, particularly in research examining historical and actuarial factors, limits definitive conclusions about differences between offenders who do and do not commit suicide. In addition, suicide research generally focuses on static risk factors and a concomitant conceptualization of suicide as a distinct occurrence. This limits the extent to which the process of becoming suicidal can be considered when prisoner suicides are examined (Bonner, 1992).

Currently there exist several suicide risk scales for the general population that have demonstrated psychometric properties (for a review, see Rothberg & Geer-Williams, 1992). In terms of long-term prediction, one instrument has been empirically derived via a large prospective study (Motto, 1985; Motto, Heilbron, & Juster, 1985). Some suicide screening instruments have been designed specifically for jail populations (Arboleda-Florez, & Holley, 1988; Sherman & Morschauser, 1989). Recently, a scale

was developed to specifically address the estimation of suicidal risk in sentenced prison populations (Polvi, 1997).

The factors deemed relevant to assessing and predicting prisoner suicide consist of those important in assessing suicidality in the general population (e.g., suicidal ideation and intent) as well as those factors that are particularly pertinent to prisoners (e.g., physical and psychosocial isolation). Furthermore, these factors are comprised of both static and dynamic factors. The selection of these factors are based on a recent publication by the author (Polvi, 1997) wherein the literature addressing suicide risk factors was extensively reviewed. In addition, the reader is referred to the scoring protocol at the end of this paper for a suicide assessment scale that was outlined in Polvi (1997).

Psychiatric History, Mental Disorder and Psychotic Symptoms

The existence of a psychiatric history elevates an individual's risk for suicidal behaviour in both the general (Clark & Fawcett, 1992; Roy & Draper, 1995; Tanney, 1992; Westermeyer, Harrow, & Marengo, 1991) and prison populations (Anno, 1985; Bonner, 1992; Burtch & Ericson, 1979; Dooley, 1990; Green, Kendall, Andre, Looman, & Polvi, 1993; Levey, 1990; Topp, 1979). Indeed, evidence from community-based suicide studies suggest a rather dramatic effect is wielded by the existence of a psychiatric history. For instance, upon reviewing six large scale psychological autopsy studies of community-based suicides, Clark and Fawcett (1992) concluded that "a recent major psychiatric disorder is implicated in no less than 93% of cases of adult suicide" (p. 18).

When compared to prisoner suicide studies, research in the general population offers more specificity in terms of the type of psychiatric history which is relevant to suicide. Clark and Fawcett's study revealed that 40 - 60% of those who committed suicide displayed major depression while 20% evinced chronic alcoholism and 10% were schizophrenic. In particular, several researchers have pointed out that young male schizophrenics are at especially high risk for suicide (Clark & Fawcett, 1992; Tanney, 1992; Westermeyer, Harrow, & Marengo, 1991). However, there are methodological impediments to precisely identifying the degree to which specific psychiatric diagnoses elevate suicidal risk since studies vary in the populations examined (e.g., in-patient, out-patient, or both), the length of follow up, and the disorders (or combination of disorders) targeted for study (Appleby, 1992).

The failure of prisoner suicide research to isolate the type of psychiatric history or psychiatric disorders that are most closely related to prisoner suicide resides in the fact that most researchers have broadly defined "psychiatric history". Usually this term refers to any previous psychiatric contact, hospital admissions, any diagnoses (specific and non-specific) and any treatment. Most likely the lack of differentiation among these various psychiatric contacts lies in the lack of completeness or availability of prisoner files. Using this broad definition, existing research has estimated that the proportion of prison suicide samples with a psychiatric history ranges from 33% (Dooley, 1990) to 78% (Burtch & Ericson, 1979).

Depression is one specific type of psychiatric order which has a direct relationship with suicidal behaviour. However, differing uses of the term "depression" can be a subject of confusion when interpreting the research since depression may refer to a syndrome or symptom as well as mental disorder (Tanney, 1992). Despite this, based on a review of research on mental disorder and suicide, Tanney (1992) concluded that mood disorders are the most important mental disorder related to suicide. More specifically, he stated that unipolar depression and psychotic/melancholic depression are the subtypes most strongly related to suicide.

In addition to conceptualizing depression as a mental disorder, it is important to consider the role of depressive symptomatology in suicidal behaviour. Not only is it one of the classic clinical predictors of suicidal risk, the research supports a relationship between current depressive symptoms and suicidality (Beck, Steer, Beck, & Newman, 1993; Cohen, Lavelle, Rich, & Bromet, 1994; DeMan & Leduc, 1995; Drake, Gates, Whitaker, & Cotton, 1985; Drakes, Gates, & Cotton, 1986; Roy, 1982; Smith, 1986; Strakowski, McElroy, Keck, & West, 1996). In addition to empirical evidence of a causal relationship between depressive symptomatology and suicidal risk, the link between depression and hopelessness (which is another classic clinical predictor of suicide) (Beck et. al, 1993; Sommers-Flanagan & Sommers-Flanagan, 1995; Weishaar & Beck, 1992) is another compelling reason to consider the relative contribution of depressive symptoms to suicidal behaviour.

Some research has specifically identified the prevalence of depressive disorders or diagnoses among prisoner suicides. Burtch and Ericson (1979) reported that 30% of 96 individuals who committed suicide in Canadian maximum security penitentiaries had a history of depression. In a study examining the prevalence of mental disorders and suicide attempts in sample of provincially sentenced prisoners in Alberta (Bland, Newman, Dyck, & Orn, 1990), suicide attempters exhibited a higher prevalence of antisocial personality disorder (1.5 times that of non-attempters), major depressive episode (2.3 times), and anxiety and somatoform disorders (4.5 times).

Regarding psychotic symptoms, the relationships between specific psychotic symptoms and suicidal risk are not entirely clear. In part, this is due to the confusion resulting from the researchers attaching different meanings to the word "psychotic". That is, some researchers (e.g., Tanney, 1992) use the term "psychotic" to refer to a disorder, while others (e.g., Clark & Fawcett) use the term to refer to a temporary state or discrete symptom (e.g., delusions). However, overall, the literature appears to suggest that some psychotic symptoms proffer an elevated risk for suicide in people diagnosed with primarily affective disorders (e.g., depression) (e.g., Cohen et al., 1994; Fawcett et al., 1987; Roose, Glassman, Walsh, Woodring, & Vital-Herne, 1983). Clark and Fawcett (1992) stated that in schizophrenics, suicide is less likely to occur during florid psychotic states but more likely to occur with delusions of persecution (e.g., paranoia). In their review of suicide in schizophrenia, Weiden and Roy (1992) stated there is little empirical support for hallucinations as a risk factor for suicidal behaviour. However, Weiden and Roy raised an important issue in pointing out that the true effects of

psychotic symptoms on suicidality may be masked by clinical intervention or methodological difficulties. As an example of the former, they point out that clinicians tend to hospitalize schizophrenics with psychotic symptoms more often than hospitalizing depressive patients with psychotic symptoms. As a result, psychotic schizophrenics are protected from suicide and the potential influence of psychotic symptoms upon suicidal behaviour is interrupted and influenced by clinical intervention.

Substance Abuse

The use of substances impacts suicidal risk in two ways: as an historical (or epidemiological) risk factor and as a clinical risk factor (Hawton, Fagg & McKeown, 1989; Murphy, Wetzel, Robins, & McEvoy, 1992, Suokas & Lonnqvist, 1995). First, as an historical factor, the presence of a substance abuse history or dependence is predictive of an elevated risk for suicidal behaviour (Klatsky & Armstrong, 1993; Lester, 1992; Suokas & Lonnqvist, 1995; Wasserman, Varnik & Eklund, 1994). With specific reference to alcohol, Murphy and Wetzel's (1990) meta-analysis of published studies indicated that the lifetime risk of suicide for alcoholics is 60 to 120 times that of the general population. Additional research indicates that the combination of alcoholism and depression further increases the risk of suicidal behaviour (Bulik, Carpenter, Kupfer & Frank, 1990; Fawcett, Clark, & Busch, 1993; Fowler, Liskow, & Tanna, 1980; Murphy & Wetzel, 1990).

Research on prison suicides suggests that a history of substance abuse may be particularly prevalent among this population. For example, Green et al. (1993) found that 65% of 133 Canadian penitentiary suicides had a history of alcohol abuse, and that 54% of this sample had a history of drug abuse. Bland et al. (1990) found that provincial prisoners with a history of suicide attempt(s) had a prevalence rate of alcohol abuse or dependence 1.2 times greater, and a prevalence rate for drug abuse or dependence 1.4 times greater than the rates for non-attempters. Finally, a prospective 6 year follow-up study on Canadian pre-trial forensic patients revealed that both drug abuse and alcohol abuse were significant (and separate) predictors of later suicidal behaviour (in the form of thoughts, threats, attempts, and completed suicides) (Daley, 1987).

Second, as a clinical factor, the actual consumption of alcohol or drugs can elevate the risk for suicidal behaviour. Although theoretically and officially prisons do not permit the use of these substances, the reality is that these substances are present and obtainable by prisoners. Since one effect of substances includes the disinhibition of behaviour, it is important to consider the possibility that the inmate is under the influence of alcohol or drugs. In their review of studies demonstrating a relationship between alcohol consumption and suicidal action, Weishaar and Beck (1992) concluded that being an alcoholic is not a necessary condition for increasing risk since "use of alcohol at the time of suicidal ideation may increase the possibility of poor judgment, lack of control, and mood changes" (p. 471). Additional effects of substance use can occur in the form of increased aggressiveness, impaired judgment, impulsivity or involvement in high risk activities (Weiss & Stephens, 1992).

Personal and Familial History of Suicidal Behaviour

Both a personal history and a familial history of suicidal behaviour elevates an individual's risk for suicide. Research on the relationship between personal prior attempts and later completed suicide in both the general population (Maris, 1992a; Moller, 1990; Steer, Beck, Garrison, & Lester, 1988) and psychiatric populations (Allebeck, Varla, Kristjansson, & Wistedt, 1987; Roy & Draper, 1995) indicates that one or more prior suicide attempts increase the individual's risk of a later completed suicide. For example, Clark and Fawcett (1992) concluded that 18% to 38% of suicide completers had attempted suicide on a previous occasion. In addition, research (Rudd, Joiner, & Rajab, 1996) indicates that people with multiple prior attempts present with more severe clinical symptoms (e.g., severity of suicidal ideation, more hopelessness, more depressive symptomatology) than do people with a history of either suicide attempts or ideation.

The suicidal history of prisoners is consistently examined in prisoner suicide research (Anno, 1985; Bonner, 1992; Burtch & Ericson, 1979; Dooley, 1990; Green et al., 1993; Lloyd, 1990; Topp, 1979), and these studies have found that from 40% to 55% of the suicide samples had a history of suicide. There is some indication that these percentages represent a disproportionately high level of suicide attempts as compared to the general prison population. Bland et al. (1990) compared a sample of 180 randomly selected Canadian male provincial prisoners with 1,006 matched community male residents, and reported a 23% lifetime prevalence of suicide attempts among sentenced prisoners. Thus, the estimated prior attempt rate of 40% to 55% among prisoner suicides is approximately twice the rate found in Bland et al.'s sample. Of particular note is a finding (Green et al., 1993) that 94% of Canadian federal prisoner suicides had made a prior attempt within a year of the actual completed suicide. This finding is consistent with a generalization made by Maris (1992a), based on his examination of the relationship between nonfatal suicide attempts and completed suicide: "The probability of completing suicide is especially high in the first year or two after the initial nonfatal suicide attempt" (p. 374).

In terms of the role of a familial history of suicide, research has demonstrated that suicide tends to run in families, and that a genetic factor is implicated in familial histories of suicide (Kety, 1986; Mitterauer, 1990; Roy, 1992; Tsuang, 1983). Generally, first degree relatives (i.e., offspring and siblings) of people who have committed suicide are at greater risk of suicide. In addition, studies on psychiatric patient populations indicate that relatives of people with mood disorders (i.e., bipolar disorders, depression) who committed suicide are at an even greater risk of suicide (Mitterauer, 1990; Roy, 1994; Tsuang, 1983). Furthermore, research indicates the genetic factor that elevates suicide risk is independent and additive to the contribution made by a family's genetic predisposition to affective disorder (Brent, Bridge, Johnson, & ; Connolly, 1996; Kety, 1986; Roy 1992). Kety (1986) hypothesized that impulsive behaviour may be the mediating genetic factor in suicide. He suggested:

It is an interesting possibility that the genetic predisposition to suicide may represent a tendency to impulsive behaviour of which suicide is a prime example. We cannot dismiss the possibility that the genetic factor in suicide is an inability to control impulsive behaviour, while depression and other mental illness as well as overwhelming environmental stress serve as potentiating mechanisms which foster or trigger the impulsive behaviour, directing it toward a suicidal outcome (1986, p. 44).

Impulsive Behaviour

Although impulsivity is often connected with acting violently toward others, it can also be a factor in acting against the self, as in the case of attempted or completed suicide. For instance, an examination of 350 suicide attempters revealed that 40% exhibited less than 5 minutes premeditation in contemplating their act (Williams, Davidson, & Montgomery, 1980). Additional evidence of a link between impulsivity and suicidal behaviour is provided by both psychometric (Apter, Plutchik, & van Praag, 1993; Kotler et al., 1993), and biological or pharmacological research (Bourgeois, 1991; Golden et al., 1991; Stanley, Winchel, Molcho, Simeon, & Stanley, 1992).

The precise role that impulsivity plays in elevating suicidal risk continues to be the subject of research. However, the relationship between impulsivity and suicidal behaviour is often examined in relation to violent behaviour (e.g., Apter et al., 1993; Brown, Linnoila, & Goodwin, 1992; Kotler et al., 1993). Upon their review of relevant research, Plutchik and van Praag (1990) concluded that there is a definite relationship between suicide and violence. They proposed a two-stage model of suicide and violence suggesting that certain classes of events (e.g., challenges, threats, losses) trigger aggressive impulses, and that the likelihood of violent behaviour depends on a large number of factors that may serve to increase or decrease the aggressive impulse (e.g., weapons availability, history of assaultive behaviour, personality style, interpersonal style). However, "a separate set of variables determines whether the goal of aggressive actions will be other people or oneself" (1990, p. 60). They suggested that the presence and interaction of these two sets of variables (i.e., impulsivity variables and aggressiveness variables) is what ultimately determines the strength and target (i.e., others or self) of aggressive behaviour.

Upon further examination of this issue, Plutchik and van Praag (1995) concluded that both suicidal and violent patients exhibited significantly higher levels of impulsivity. In one study, when the relationship between impulsivity and violence was partialled out, the correlation between impulsivity and suicide risk was +.22. Some additional support for a relationship among impulsivity, suicidal behaviour, and violence is offered by Bergman and Brismar (1994) who investigated the hormonal levels and personality characteristics of 49 male alcoholics as these factors related to the patients' violence and suicidal history. They found a significant positive correlation between the number of prior violent episodes and the number of suicide attempts. Psychometric measures of impulsivity and muscle tension significantly differentiated patients with or without prior suicide attempt(s). Bergman and Brismar concluded: "Our results confirm that there is a positive correlation between suicidal and abusive behaviour. As the correlation

coefficient was 0.33, ~ 10% of the variation in suicide attempts in this material can be explained by the abusive behaviour" (1994, p. 313).

Overall, though the relationship appears complex, the empirical research suggests that impulsivity is associated with an increased risk of suicidal behaviour. Even if this relationship is mediated or determined by proneness to violence, this is reason enough to consider it in a population of federally sentenced prisoners, since such a population will undoubtedly contain a high proportion of individuals who have demonstrated histories of violent behaviour.

Suicidal Ideation, Intent, and Plan

Traditionally, assessment of suicidal risk has involved determining the presence of ideation, intention and planning with respect to suicide (Fremouw, de Perczel & Ellis, 1990; Sommers-Flanagan & Sommers-Flanagan, 1995). Beck and his colleagues have developed scales for assessing some of these classic clinical factors (for a review of these scales, see Eyman & Eyman, 1992 and Weishaar & Beck, 1992). Indeed, by operationalizing suicidal ideation, suicidal intent, depression and hopelessness, Beck and his colleagues have been able to demonstrate empirically that these clinical factors are associated with an elevated risk for suicidal behaviour. Such scales assist both in the clinical assessment of individuals and in research on suicide.

Assessing a client's suicide plan involves examining several factors: the specificity of the plan, the lethality of the intended method, the availability of means, and the proximity of help or rescue (Bednar, Bednar, Lamber, & Waite, 1991; Sommers-Flanagan & Sommers-Flanagan, 1995). Particularly relevant is the chosen suicide method and its inherent lethality.

McIntosh (1992) defined "lethality" as the probability of death as presented by a particular method and explained that lethality consists of two components. The first component is the elapsed time between initiating the suicidal act and death, with shorter time period being associated with greater lethality. The second component is the potential for and availability of medical intervention after the method has been used. Using official U.S. mortality statistics of deaths attributable to various methods across three demographic variables (sex, age and ethnicity), McIntosh found that the use of firearms was consistently the most common method of suicide across sex and age groups, and all but two ethnicity categories. Hanging was the second most common method among males, whereas the use of solid or liquid poison was the second most common method among females.
Given that research reveals hanging to be the predominant method of suicide in prison (Anno, 1985; Bonner, 1992; Burtch & Ericson, 1979; Dooley, 1990; Green et al., 1993; Hardyman, 1983; Lloyd, 1990; Salive, Smith & Brewer, 1989; Schimmel, Sullivan & Mrad, 1989; Topp, 1979), prison staff may wish to inquire specifically about this method with the prisoner. In this respect, it is especially important to have precise knowledge of the potential means within the prisoner's living space.

Hopelessness

Theory and research related to cognitive therapy as pioneered by Beck and his colleagues have indicated that hopelessness is one of the key factors related to suicidal behaviour (Weishaar & Beck, 1992). Defining "hopelessness" as "a state of negative expectancies" (p. 471), Weishaar and Beck (1992) reviewed the research demonstrating the relationship between hopelessness and facets of suicidal behaviour. Their statement that hopelessness is more strongly associated with suicidal intent and ideation than is depression was supported by subsequent research, which demonstrated that hopelessness in mood disordered patients was 1.3 times more important than depression in predicting suicidal ideation (Beck, Steer, Beck, & Newman, 1993). Overall, after examining both prospective and longitudinal research, Weishaar and Beck (1992) concluded that the construct of hopelessness has predictive utility in regard to suicidality.

Consistent with such a conclusion, two studies have supported hopelessness as a significant predictor of suicidal behaviour in sentenced prisoners (Holden, Mendonca, & Serin, 1989; Ivanoff & Jang, 1991). In addition, these studies have demonstrated that social desirability interacts with hopelessness in the prediction of suicidality. However, the respective researchers have offered differing interpretations of this interaction, which may well be a result of their using two different social desirability measures. In discussing their research, Holden et al. (1989) suggested that higher levels of perceived self-efficacy moderate the relationship between hopelessness and suicidality. In their paper, Ivanoff and Jang (1991) stated that the interaction involves an inverse relationship between hopelessness and social desirability, whereby the predictive ability of hopelessness decreases as social desirability increases.

Sudden Change in Psychological Functioning

Traditionally, in the clinical assessment and treatment of suicidality, a sudden, unexplained change in an individual's mood and/or functioning has been associated with increased risk of suicide. Both Fremouw et al. (1990) and Maris (1992b) have discussed this clinical sign as it relates to depressive illness, and Drake, Gates, Whitaker and Cotton (1985) have concluded that it is a factor relevant to suicidal behaviour in schizophrenics. Generally, it is thought that a slight improvement in a client's mental illness makes energy available for the client to act on suicidal intentions or plans. Having made the decision to commit suicide, the client may experience a reduction in tension or ambivalence and present a better mood than previously. Since it is not hard for correctional and clinical staff to be beguiled by such superficially positive signs, staff should be suspicious when any such sudden change occurs and explore this issue accordingly.

Stress, Vulnerability and Coping

Reviewers of the research literature on the relationship between both recent and long standing stressful life events and suicidality have concluded that such circumstances can play an important role in an individual's suicidal behaviour (Heikkinen, Aro, & Lonnqvist, 1993; Yufit & Bongar, 1992). However, Yufit and Bongar (1992) cautioned that this is not a simple and direct relationship. Rather, they stated that stressful life events "must be contextualized within the larger overall picture of the individual's personality structure and lifelong characterological ability to cope with (or to be vulnerable to) stress, failure, and loss" (p. 557). Significantly, some research indicates that life stressors in general (Heikkinen et al., 1993) and interpersonal loss in particular (Murphy & Wetzel, 1990) may exacerbate the suicidal risk of alcoholics.

Bonner (1992) described the occurrence of prisoner suicide in a similar vein by referring to a "stress-vulnerability process" (p. 406). By drawing on the suicidology literature, which conceptualizes suicide as a process occurring over time, he hypothesized that "certain individuals are unprepared, ill equipped, and/or at a loss for resources to cope effectively with incarceration" (p.415). Risk factors such as loneliness, alienation, and isolation break down the coping mechanisms of these individuals. Thus, they are left vulnerable to negative life events. Bonner concluded that the interaction of these risk factors and negative life events is what may lead to emotional breakdown over time, and, given certain conditions, to eventual suicide. Subsequent research (Bonner & Rich, 1992) has lent some support to this hypothesis by demonstrating a relationship between cognitive vulnerability and hopelessness in a sample of correctional inmates.

Levey's (1990) review of prisoner suicide and Liebling's (1995) research (both of which concentrated on U.K. prisoners), lend support to the proposed role of stress, vulnerability, and coping ability. In particular, Liebling's research is informative. Drawing subjects from four institutions for young offenders, three remand centers, and one prison, Liebling's research involved interviewing 100 prisoners who had attempted suicide and 112 randomly selected prisoners who had not attempted suicide. In

comparing the two groups, she found significant differences in background variables and characteristics of their prison life. She used the term "vulnerable" to describe the attempters, and stated that "their vulnerability, characterized by a history of adverse life circumstances followed by persistent problems in 'coping', was exposed by many different aspects of the prison world, from activities and relationships to planning for the future" (p. 179).

Liebling realized that a large proportion of the prison populations shared the characteristics of her suicide attempter group. Therefore, she examined completed suicides in England and Wales from 1987 to 1993 and identified three distinct groups, which differed in age, history of self-injury, motivation for suicide and situational factors attributable to death. Not only did she demonstrate that one of the three groups closely resembled the vulnerable "poor copers" who consisted of most of the attempters in her study; she also showed that this same group accounted for more completed suicides (30 - 45%) than the other two groups combined. Consistent with Liebling's research is a study based on the completion of self-report scales by prisoners who had attempted suicide or perpetrated intentional self harm (Holden et al., 1989). The authors concluded that higher levels of capability or self-efficacy on the part of prisoners moderated the relationship between hopelessness and suicidality.

As is evident from the eleven profiles in the preceding report, a variety of stressors can contribute towards an inmate's suicidality. Worth considering in particular, however, might be the recent diagnosis or presence of serious health conditions such as HIV/AIDS or Hepatitis C. The increasing prevalence of such diseases in the inmate population (Pagliaro, 1992), may translate into an increased incidence of suicidal behaviour and completed suicides. Furthermore, in addition to a direct impact in terms of an absolute increase of suicidality (e.g., through increased hopelessness), maladaptive coping with such diseases due to generally poor coping ability or vulnerability (as per Liebling, 1995) may further exacerbate the typically serious impact of life-threatening disease upon an inmate's well-being. More simply put, one could hypothesize that the increasing incidence of certain diseases will elevate the incidence of suicidal behaviour in inmates as a group as well as heighten the risk of suicide in individual cases wherein poor coping and vulnerability are present. The combination of these two factors would suggest a significant impact upon the amount of suicidal behaviour within Canada's federal penitentiaries.

Isolation

There are two types of isolation that appear relevant as risk factors in the suicidal prisoner. The first is physical isolation. Research on prison and jail suicide has revealed that a disproportionate percentage (60 - 79%) of suicides occur while the prisoners are confined to locations that are remote from the general prison population (Bonner, 1992; Burtch & Ericson, 1979; Hayes, 1989; Liebling, 1992; Lloyd, 1990; Schimmel et al., 1989). Typically these locations are isolation cells in a segregated area of the prison/jail, but they may also include single cells in observation units or psychiatric/medical units of a prison.

The second type of isolation is psychosocial, in which the prisoner is isolated from emotional and social sources of support (Sherman & Morschauser, 1989). A lack of social support has been identified as a risk factor for suicidality in a number of populations (Drake et al., 1986; Heikkinen et al., 1993; Kotler et al., 1993; Roy, 1982; Veiel, Brill, Hafner, & Welz, 1988). With respect to prisoners, Bonner (1992) outlined the potential mechanisms by which physical and psychosocial isolation interact and contribute to enhanced suicidal risk. He suggested that those in prison experience psychosocial isolation, and that some individuals are more vulnerable to both isolation and life stressors than are other prisoners. These vulnerable persons, who are already apt to be at heightened risk for suicidal behaviour, tend to be at even greater risk with the addition of physical isolation.

Actuarial Risk Factors

Several actuarial factors related to the risk of prisoner suicide are consistently mentioned in the research literature. Unfortunately, these factors alone tend to provide low predictive ability, because they are common to a large proportion of the prisoner population and are not limited to prisoners prone to suicide. In addition, because of methodological weaknesses such as the lack of comparison groups in many studies (Bonner, 1992; Haycock, 1991; Liebling, 1992; Lloyd, 1990), the research results are difficult to interpret. However, given the consistency of the literature in relating these factors to prisoner suicide, it appeared important to consider them. The following is a summary of these actuarial factors: age, marital status, sentence length and time served in sentence.

In contrast to studies of suicide in the general population, which demonstrate that suicide occurs disproportionately in older age groups (i.e., those aged 45 and over; Clark & Fawcett, 1992; Garrison, 1992; Maris, 1992b), research on prisoner suicide (Bonner, 1992; Hatty & Walker, 1986; Lloyd, 1990; Salive, Smith, & Brewer, 1989) indicates that prisoners who commit suicide tend to represent the younger age groups. Although no clear age cutoff emerges from the research, Liebling (1992) concluded from her review that the ages of prisoners who completed suicide were below the mean prisoner age in many studies. Salive et al. (1989) reported that the highest rate of prisoner suicide occurred in the 25 to 34 age group, whereas Schimmel et al. (1989) found that the highest proportion of prisoner suicides took place among those aged 30 to 39. Hatty and Walker (1986) reported that, compared to the general prison population, the highest proportion of Australian prison suicides occurred in the 20 to 29 age group, and the second highest in the 30 to 39 age group. Burtch and Ericson (1979) also found a bimodal distribution in their Canadian study, in which younger inmates (aged 15 to 24) and older inmates (aged 50 and above) were more prone to commit suicide. CSC data presented in this report shows that over the last six years, the largest number of suicides have occurred in the 30 to 39 age group.
As in the general population, where unmarried males (Maris, 1992b) are more prone to suicide, single prisoners appear to be at greater risk of suicide (Backett, 1987; Burtch & Ericson, 1979; Dooley, 1990; Topp, 1979). Although most of the studies reviewed by

Liebling (1992) suggested that the majority of prisoners committing suicide are single, she pointed out that comparison groups were rarely used in these studies. Lloyd (1990) stated that U.S. and British studies agreed that between 70% and 80% of prisoners who committed suicide were not married. He noted the lack of control groups in the relevant research, but stated that in studies where control groups were used, the results demonstrated that comparatively more prisoner suicides were single. Lloyd also pointed out a confounding factor: the research generally does not account for cohabitation of unmarried prisoners.

Most reviewers have concluded that prisoners with longer sentences are disproportionately represented among suicides (Bonner, 1992; Haycock, 1991; Hayes, 1995a; Liebling, 1992; Lloyd, 1990). Indeed, some have suggested that those serving life sentences constitute a distinct sub-group in terms of presenting elevated risk for suicide (Haycock, 1991; Liebling, 1992; Lloyd, 1990). Some researchers have found no relationship between sentence length and prisoner suicide (Anno, 1985; Green et al., 1993), but others have done so. Dooley (1990) found the highest suicide rate among prisoners serving sentences of 4 years or longer, whereas Topp (1979) found the highest rate among prisoners serving more than 18 months. Burtch and Ericson (1979) reported that two groups were over represented among federal prisoner suicides: (1) prisoners serving 2 to 4 years, and (2) those serving life sentences. Hatty and Walker (1986) concluded that prisoners serving indefinite sentences are disproportionately represented among prisoner suicides. One difficulty in interpreting research findings relating sentence length to suicide is that sentence length is confounded with seriousness of crime, given that more serious and/or violent crimes tend to result in longer sentences (Haycock, 1991; Lloyd, 1990).

Generally, prisoners who commit suicide tend to do so early in their sentences (Burtch & Ericson, 1979; Dooley, 1990; Green et al., 1993). However, as Lloyd (1990) pointed out in his review, it is difficult to assess the available research on this variable, since researchers typically have not clearly differentiated between sentenced and unsentenced prisoners in their samples. Studies on suicide in temporary detention facilities (e.g., police lock ups, remand facilities, jails) indicate that a disproportionate number of offenders commit suicide within 24 hours of lock up (Hayes, 1989). Lloyd's (1990) overall conclusion regarding this population was that there is a high rate of suicides within the first 2 weeks of remand custody. Studies using samples of either exclusively sentenced prisoners or a combination of remand and sentenced prisoners suggest very broadly that 3 months and 2 years may be important milestones. Upon examining a Canadian sample of 133 federally sentenced prisoners, Green et al. (1993) found that 25% committed suicide within 90 days of sentence commencement, and that a total of 51.5% had committed suicide within 1 year of beginning their sentences. In an earlier sample of federally sentenced prisoners, Burtch and Ericson (1979) calculated that 60.2% of 96 inmate suicides occurred within the first year of sentence, whereas an additional 21.9% of suicides occurred within 13 to 24 months of sentence commencement. Hayes (1995a) cited a study completed by the New York State Department of Correctional Services, in which 64% of 53 prisoner suicides were found to have been committed within the first 2 years of sentence. In a sample of 186 English

prisoners (of whom 37% were remand or unsentenced) who committed suicide, Topp (1979) found that 61% committed suicide within 3 months of entering custody (the cumulative percentages at the 1, 2, and 3 month marks were 41.5%, 53% and 61%, respectively).

CONCLUSION

As can be seen from this literature review, the assessment of suicidal risk generally as well that particular to sentenced prisoners, requires the consideration of multiple factors. This effort to highlight and summarize the factors relevant to assessing suicidality in incarcerated populations could be viewed as a guide to the forensic clinician in assessing the level of a prisoner's suicidal risk. The reader is referred to the Case Study which serves a real-life example of multiple factors to consider in assessing suicide risk. In addition, this case study illustrates several important points. First, upon reading the case, it is quite evident that the previously outlined factors relevant to suicide risk do not make equal contributions to such risk. Indeed, the historical factors in David's case make a limited contribution to his high risk. Rather, his high level of risk is heavily influenced by clinical factors. This, in turn, illustrates a second point; one which was outlined earlier in terms of distinguishing between short-term and long-term prediction of suicide risk. The case study of David is consistent with the suggestion that short-term assessment of suicide is heavily dependent upon the presence and severity of clinical dynamic factors. While demographic (or actuarial) and historical factors should be taken into consideration, it seems that for short-term risk assessments the clinical factors "make or break" the assessed level of risk. Finally, this case study illustrates the considerable resources sometimes required in resolving a case of prisoner suicidality. Indeed, as in the case of David, at times this large expenditure of resources continues across a significant period of time.

It should be noted that the majority of prisoner suicide research focuses on the suicidal risk factors related to the male prisoner. However, the risk factors outlined in this paper may provide some assistance in assessing suicidality in female offenders as well. Liebling (1994) has outlined the commonalties and differences in suicide risk factors between male and female prisoners. The common factors include being at an early stage of custody, being mentally disordered, being charged or convicted of murder, having a history of drug or alcohol abuse, making previous suicide attempts, and being physically isolated in the prison. The risk factors specific to female prisoners include having a history of arson or violence, having major alcohol problems and having many self-inflicted injuries.

Finally, it is recognized that assessing an individual's risk of suicide is only one element in the management and treatment of suicidal behaviour. However, it was not the intention here to discuss the separate issue of management of the suicidal client. There are several good sources to consult in this regard. A portion of Bongar's (1992) edited book is devoted to the management and treatment of suicidal clients. Bednar et al., (1991) provide two excellent chapters in which they discuss clinical interviews, case management and the mental health professional's legal duties with respect to suicidal clients. It is also recommended that the reader consult articles on standards of care, despite the fact they are not tailored to prisoner suicide (Bonger, Maris, Berman, Litman, & Silverman, 1993; Silverman, Berman, Bongar, Litman, & Maris, 1994). With particular reference to the correctional population several sources can be consulted regarding the management of suicidal prisoners (Lester & Danto, 1993; Rakis &

Monroe, 1989`; Rosine, 1995) and suicide prevention in prison settings (Hayes, 1995b, 1995b; Liebling, 1992).

CASE STUDY

Name: David S.
Age: 23
Criminal History:
Present Offence: Sexual Assault
Sentence: 5 years
Past Offence: Possession of a Drug (marijuana)
Disposition: Probation

Background

April 19:

During a conversation with his sister, inmate David S. found out his mother (who lives in the West Indies) is terminally ill and expected to die within 3 weeks. David then phoned his girlfriend for comfort but ended up feeling worse because she was dealing with difficulties of her own; specifically, she seemed to be having a hard time accepting David's ongoing imprisonment. Earlier in the day David learned that the National Parole Board will need to defer his parole hearing for 3 months due to lack of documentation. Initially this did not concern David given his deportable status and his desire to stay in Canada. Indeed, David felt that his life was in Canada: his girlfriend, with whom he had lived common-law prior to imprisonment, lives permanently in Canada and David believed there to be better job opportunities in Canada. However, upon hearing the news about his mother, whose last wish is to see all of her family before she dies, David's perception of this deferral changed. The deferred hearing now represented a hindrance to David's desire to see his mother.

Referral

April 21:

David was referred for a suicide risk assessment by the sex offender program therapist. Information divulged in the therapy group and the inmate's deterioration in functioning (i.e., social withdrawal, depressed mood, unwillingness to contract to commit no self-harm) over the course of the last 24 hours elicited the therapist's concern.

Issues apparent in initial interview on April 21

Inability to see mother before death

David reported he not only wants to fulfill his mother's last wish but he also wants to see his mother to tell her about all he has learned through therapy. In addition, he reported that her death would place certain duties and obligations upon him. For instance, it would be his responsibility to light the funeral pyre.

Guilt, self blame, and prior unresolved grief reaction

David exhibits a lot of self blame in the form of feeling responsible for the deterioration of his mother's health by being in prison for the last two years; not living up to his duties and obligations of being present when his grandparents died in the past and now his mother's impending death. Also prominent in his thinking is blaming himself for the death of 2 young children when he was aged 11. While playing in the ocean water near his home, he encouraged two young children to enter the water where he was playing and they subsequently drowned. At the time, apparently he vaguely explained the circumstances of this event to others but they are not aware that he continues to feel responsible for and guilty about the children's death. After this event David ran away to an empty country home owned by his father. He states that's how he deals with things - he runs away. Overall, he reports a history of his perceived inability to cope with negative emotions and loss.

Clinical symptom (emotions and vegetative functions)

David reports that this all seems "too big to handle" and feels if he is pushed any further (e.g., hears that his mother has died) he will "go over the edge". He dreads calling home. He feels helpless about the situation; for instance, he feels unable to comply with his mother's last wishes. David feels unable to cope with the sadness and grief of his mother's impending death. David expresses hopelessness about his future, his actions to better himself and the relationships in his life. He perceives there would be little impact on others should he die. David reports eating nothing and not sleeping at all for the past three days. He also reports poor concentration and confused thinking particularly yesterday evening.

Past suicidal behaviour

David describes two past suicide attempts: (1) Seven months ago, David reportedly tried to starve himself for two months by eating no food and only drinking water. This was in reaction to his perception that his girlfriend was experiencing personal difficulties and would commit suicide. Thus, he attempted to avoid the pain of this event by starving himself to death first. After an improvement in his girlfriend's situation, he abandoned this action. (2) David reported that while at the federal regional reception unit at the beginning of his sentence (about two years ago), he was sexually assaulted by his cell mate. David did not tell staff. To prevent people from finding out about the assault, the aggressor forced David to attempt to hang himself (e.g., the aggressor made the sling that David used to attempt suicide). There appears to be unresolved

issues relating to this experience that are understandably surfacing at this time of crisis. Apart from these clinical concerns, there is no evidence that David has ever been diagnosed as having a mental disorder or experienced psychotic symptoms. He states he has never sought psychiatric or psychological treatment while in the community. He was under the influence of alcohol at the time of his offence but he insists he does not have an alcohol problem. There is evidence of casual illicit drug use while in the community but not while in prison. David denies a familial history of either suicidal behaviour or mental disorder.

Suicidal Plan

David has a plan and a method of suicide which he stated he has practiced since the age of 16. He claims to need no knife, rope, or the like and he is not concerned with potential pain associated with the act. He would not detail the method but stated that the last time he practiced was six months ago. David stated he observed this action when a friend performed it in his home country. David states that his own adoption and practice of the action was at first a joke but he has since perfected it to a point where no pain is experienced. Upon questioning whether this is a risky action to practice, David replied there was some risk but he was so good at it that the risk was minimal. He reports he once almost went unconscious practicing this action but he was "strong enough" to recover. Based on David's description, this form of suicide is likely a form of asphyxiation or self-choking. The way in which David details it, it is as if he has known all of this life that he will some day need to use the method to escape and avoid pain and thus has had this perfected technique at the ready.

In the interview, David refuses to verbally contract to do no harm to himself. He feels that he may reach a breaking point when he learns his mother has actually died. David does not plan to phone his family this evening. David vehemently opposes any transfer to segregation for monitoring purposes. He threatened to commit suicide for revenge if such a transfer took place.

Assessment and Action

David is assessed to present a high risk for suicide. Based on the present description of his case, David's risk is heavily influenced by clinical factors. Historical factors in the form of personal or familial mental disorder do not appear to be present. While there is no familial history of suicide, his personal history of suicidality raises concerns. Although David's last attempt was a passive one, it is quite a recent attempt. Clinically, he has a high level of suicidal ideation and intent as well as a specific plan of seemingly high lethality. He presents as quite hopeless about his present situation and the future. It is evident that he is experiencing many stressors with a concomitant limited ability to cope. Not only does he see the present stressors as overwhelming, available information about his background suggests he has history of inadequate coping. As a part of these stressors, one must consider the unresolved clinical issues (his own victimization in a sexual assault; self blame regarding the children's death; poor coping abilities in general and poor coping with emotions in particular) as important. Indeed, it

appears that these issues may well have to be addressed in some way to assist in alleviating David's suicidality. A final relevant clinical issue is that David presently feels socially isolated since he perceives receiving limited emotional support from his girlfriend and his family members are geographically distant. The lack of psychotic symptoms and no evidence supporting active substance use within prison, however, are favourable indications. In terms of actuarial or demographic factors, David would be considered at high risk due to his young age and time served in prison (i.e., he appears to be within the two-year mark).

Despite evidence in the literature that segregation is contraindicated in the management of suicidality, with some high risk cases this must be considered as an option with the costs and benefits being weighed accordingly. In the present case, given the high risk, there is need for monitoring. However, in this case given David's vehement refusal to consider going to Segregation, such a placement could precipitate suicidal behaviour. Given this state of affairs, the clinician's decision for the short-term management and monitoring of this inmate is to keep David in his cell on the unit in population and implement an hourly watch. David agreed to the clinician's action of contacting an inmate buddy to transmit a request for the buddy to visit David during that same evening and "pal" around with him.

For the foreseeable future, David is considered to be a high risk for suicide and the institution may not be able to adequately monitor him (i.e., there is no observation cell) and there may not be sufficient therapeutic resources to assist him in addressing the clinical issues that underlay his ongoing suicidality. David was referred to the Ambulatory Care Services (ACS) nurse of the Regional Psychiatric Centre (these proper names are used generically and are not intended to refer to any specific entity or institution) and the situation was discussed at the institutional Mental Health Care Meeting. The ACS nurse and the Mental Health Team concurred that the inmate presented as an ongoing high risk for suicide. It was agreed that consideration should be given to involuntarily transferring David to the Regional Psychiatric Centre if he is unwilling to go voluntarily.

Outcome

David's case presented a number of challenges in terms of ongoing suicide risk management. While he refused a voluntary transfer to the Regional Psychiatric Centre, those involved in the case unanimously expressed grave concerns about his high risk and the difficulties in managing his risk within the institution. Two options related to involuntary transfer were available: 1) request intervention by a physician in terms of certifying the inmate under the provincial mental health act based on the criterion of impending harm or death to himself, or 2) involuntarily transfer the inmate based on provisions within the Corrections and Conditional Release Act. Resource and logistical difficulties provided complications in effecting the first option: no physician was available until the following day and there were some complications in transporting the inmate to a local physician. Thus, with the assistance of key institutional staff (e.g., Case Management Officer, Deputy Warden, Unit Manager, Coordinator of Case

Management, Correctional Supervisor) an involuntary transfer was effected and the inmate was transported that evening.

The next day, David's friend was interviewed and spontaneously provided corroboration of David's high level of suicidality. On the same day however, a very unusual twist in the case occurred when the Ambulatory Care Nurse reported that, in the interview with the psychiatrist (during which the nurse was present), David flatly denied any suicidal ideation. David was described as exhibiting no evidence of mood disorder or thought disorder. In the same interview, David promised not to harm himself. Given their previous observations and contact with David, the nurse and psychologist opined that David was malingering wellness. Nonetheless, psychiatric centre's decision was to discharge David back to his parent institution immediately. The next day David was returned to the institution.

In response to the ACS nurse's insistence, David reluctantly agreed to be interviewed by his CMOI, COII and psychologist upon his return. David confirmed suspicions of malingering by stating that he "put on a Mr. Nice Guy act" at the psychiatric centre. He felt angry at and betrayed by the institutional staff's actions. He intensely disliked being at the psychiatric centre and insisted it was a place for crazy people and not himself. David was assessed as presenting a high risk and placed on an hourly watch within the unit. The rationale for choosing to place him in unit as opposed to Segregation remained the same as that outlined previously. While David promised to not harm himself, his recent successful malingering provided a compelling reason to not believe his promise.

Thereafter, David's risk was managed via frequent counselling sessions, efforts to obtain conditional release and continuation of the hourly observation on the unit. Observation continued for 10 days and counseling consisted of addressing some of the most important clinical issues evident in the initial assessment (e.g., his feelings of guilt and blame). Of course, renewing the therapeutic alliance was made difficult by David's feelings of betrayal surrounding the transfer. However, this obstacle was surmounted. In addition, his Case Management Officer worked on expediting an emergency review by the National Parole for consideration of Day Parole and subsequent deportation to the West Indies thus enabling him to see his mother. Gradually, therapeutic contacts were decreased and David's suicidal risk subsided. His situation was finally resolved when he was granted Day Parole and deported to the West Indies.

Estimate Of Suicide Risk (ESR)

Name: _____ Sex: M / F Age: ___ _____

Institution: _____ Examiner: _____

PART 1. ASSESSMENT

Score each item as 0, 1, or 2. Items with asterisks are items especially important to risk.

Historical and Actuarial Factors	0	1	2
1. Psychiatric history			
2. History of alcohol or drug abuse			
3. Prior suicide attempt(s)			
4. History of impulsive behavior			
5. Family history of suicide			
6. Age			
7. Marital status			
8. Sentence length			
9. Time served in sentence			
Clinical Factors			
10. Suicidal ideation			
11. Suicidal intent*			
12. Suicidal plan*			
13. Hopelessness*			
14. Sudden change in psychological functioning *			
15. Stress, vulnerability and coping			
16. Depressive symptomatology			
17. Current use of alcohol or drugs			
18. Psychotic symptoms (e.g., delusions)			
19. Physical isolation (e.g., segregation/dissociation)			
20. Psychosocial isolation			
Column Totals			
Total (Columns 0, 1, and 2)			

PART 2. ACTION

Security supervisor notified Yes: ☐ No: ☐

Monitoring recommended: Yes: ☐ No: ☐

If 'Yes', indicate frequency: Continuous ☐ 15 minutes ☐ 30 minutes ☐ Other (please specify) _____

Referral made to another mental health professional? YES ☐ NO ☐

Referral to: Psychiatrist? Yes ☐ No: ☐ Other? specify _____

Other recommendations:

Date: _____ Time: _____ Assessor's signature _____

[4] The ESR is still only a guide for the forensic clinician since predictive validity has not yet been established. The scoring guide may be obtained by contacting the author, Natalie H. Polvi at the Regional Psychiatric Centre, Prairie Region.

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